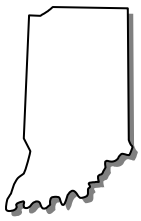
EDS Managed Care Unit



INDIANA HEALTH COVERAGE PROGRAMS

Managed Care Organizations' Policies and Procedures Manual

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Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	July 2000	All	New Format	EDS Document Management Unit
Version 2.0	August 2001	All	Rewrite	MCO SME
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Table of Contents

Section 1: Introduction

Overview

The *Managed Care Organizations' Policies and Procedures Manual* is provided to each Managed Care Organization (MCO) contracting with the Indiana Office of Medicaid Policy and Planning (OMPP) to administer services to Hoosier Healthwise members enrolled in a managed care plan. The **Error! Not a valid bookmark self-reference.** of this manual is to provide an overview of the following:

- The Hoosier Healthwise program
- The MCO's role in the Hoosier Healthwise program
- The policies and procedures specific to the MCOs' delivery of services to Hoosier Healthwise program members
- The interfaces among the MCOs and the OMPP and its contractors

This manual is organized into the following sections:

- *General Information* gives a broad understanding of the Indiana Health Coverage Programs (IHCP), including the Hoosier Healthwise program, its objectives, and components. This section also outlines the communication processes for addressing operational and policy matters.
- *Managed Care Organizations*' includes the eligibility requirements and the expected role in the Hoosier Healthwise program are outlined in addition to the coordination of the risk-based managed care (RBMC) networks with the fee-for-service program.
- *Managed Care Services* defines covered services, non-covered services, MCO-excluded but IHCP-covered services (carve outs), and program requirements specific to the MCOs.
- *Member Services* details the regulations and general program expectations relating to member education and enrollment including helpline, grievance, and member-provider communication information.
- *Provider Enrollment* details the MCOs' requirements for enrollment, education, and practice standards for network providers who render services to Hoosier Healthwise members.
- *Member Eligibility and Enrollment* describes the categories of IHCP members who must enroll in Hoosier Healthwise as well as those who may voluntarily enroll, how the enrollment occurs, eligibility verification, disenrollment of members from the program, and the data exchange processes required for each of these events.
- *Network Development, Services, and Data* describes the requirements and processes with respect to eligible MCOs and providers, network development, enrollment processes, disenrollment processes, and reporting requirements.
- *Quality Improvement Program and Performance Reporting* is a critical aspect of managed care and is described with regard to expectations, monitoring, and reporting.
- *Management Information Systems* and reporting requirements of the MCOs are described in reference to shadow claims, third party liability (TPL), and general financial reporting.
- *MCO Payment Process* mechanisms are described for payment and adjustment of capitation fees.
- *Children's Health Insurance Program* (CHIP) describes the expansion to the IHCP benefits established by the Balanced Budget Act of 1997.

Since its inception in 1994, Hoosier Healthwise has expanded from a Medicaid managed care program to an all-inclusive plan of benefits serving various populations eligible for the IHCP. Unless otherwise noted, mention of Hoosier Healthwise in this manual refers to the managed care component of the IHCP and the areas in which the MCOs have an interest.

This manual is intended to document Hoosier Healthwise policies and procedures applied to the managed care component of the program in general, as well as matters specific to MCOs and their roles in the program. General policies and those detailed elsewhere are referenced and not duplicated in this manual. Unless otherwise noted, technical specifications referred to in this manual are provided in the MCO orientation package described in *Section 8: MCO Enrollment and Network Development.*

The health care industry, and managed care in particular, constantly changes to meet the demands of its patients, providers, and payers. Hoosier Healthwise is subject to many of these changes. To meet its objectives, Hoosier Healthwise is a fluid program that strives to meet the needs of its many constituents. The OMPP provides many forums – both formal and informal – designed to address the concerns of Hoosier Healthwise participants and refine its policies to reflect the input received. These policies are documented in signed, numbered Managed Care Policy Statements that are distributed to program participants when they are finalized. These policy statements are incorporated into updates of this manual.

MCO Orientation

When the MCO contract with the OMPP is finalized, the OMPP schedules a series of orientation sessions with the MCO to review policy and technical procedures necessary to contract administration, including interfaces with the OMPP and its contractors. The MCO identifies an implementation team to participate in the orientation that likely includes staff from these functional areas:

- Provider network development and enrollment
- Technical and systems support
- Medical policy
- Member services and enrollment
- Quality assurance and utilization review

The OMPP designates members from its staff, as well as contractor representatives, to work with the MCO on implementation issues. During orientation, the OMPP and its Hoosier Healthwise contractors provide the MCO with a broad range of materials.

The fiscal agent provides the following:

- Resolutions manual for claim processing edits and audits
- The *IHCP Provider Manual* (also available on CD-ROM or on the Web at http://www.indianamedicaid.com/)
- Schedules for financial cycles for capitation payments
- Schedules for generation of all other information both to and from the MCO
- IHCP provider update bulletins, banner pages, and newsletters for the current year (available at http://www.indianamedicaid.com/)
- Electronic file layouts and requirements for all data exchanges, including provider network files, member enrollment rosters, capitation payment files, and third party liability files
- *Companion Guides for General Information, Communication Guide, Reports and Acknowledgements, 270/271Eligibility Benefit Transaction, 276/277 Claim Status Request and*

Response Transaction, 278 Prior Authorization Review Request and Response Transaction, 834 MCO Benefit Enrollment and Maintenance Transaction, 835 Remittance Advice Transaction, 837 Dental Claims Transactions, 837 Professional and Encounter Claims Transactions, 837 Institutional Claims and Encounter Transactions, and *Hoosier Rx Payer Sheet*

- User ID and password for access to electronic files, including member enrollment rosters and capitation payments
- MCO enrollment information and procedures
- Network PMP enrollment and disenrollment procedures
- Format for monthly managed care policy and operations meetings and procedure for submission of agenda items
- Technical Meeting

The OMPP or its designee provides the following:

- Orientation meeting schedule
- Prescription drug and over-the-counter (OTC) formulary information
- Resource-based relative value scale (RBRVS) and other relevant fee schedules
- Diagnosis-related grouping (DRG) information and base rates
- Phone numbers for the OMPP, AmeriChoice Corporation, and EDS contacts
- Annual IHCP report and other program summary reports
- Managed care meeting schedule

The enrollment broker provides the following materials:

- Member education video and other Hoosier Healthwise member materials including the PrimeStep member handbook
- BA script for member education and enrollment process
- Hoosier Healthwise Prime*Step* PMP manual
- In-service training opportunities

The MCO monitoring contractor provides the following materials:

- Readiness review criteria
- Quarterly reporting requirements and schedule

The medical policy contractor provides the following materials:

- Schedule for medical policy meetings

The OMPP arranges orientation sessions for each newly-contracted MCO. Orientation sessions are not routinely conducted for each contract renewal for an incumbent MCO. At the time of a contract renewal, an incumbent MCO can request the orientation session to accommodate changes in networks or other transitions for which they believe an orientation session would be beneficial. The MCO must make this special request in writing to the OMPP and state whether it wishes to participate in the entire session or a limited session to review specified topics.

Section 2: General Information

Indiana Health Coverage Programs Overview

The Indiana Health Coverage Programs (IHCP) is the umbrella for Medicaid and other State programs such as 590 (health benefits for institutionalized individuals), the Children's Health Insurance Program (CHIP), and Hoosier Rx. Established in 1965 by Title XIX of the *Social Security Act*, Medicaid is an entitlement program that finances medical services for certain individuals and families with low incomes and resources. Within broad federal guidelines, a state or territory retains responsibility for the following:

- Establishing its own eligibility standards for program members
- Determining the type, amount, duration, and scope of medical services offered
- Setting payment rates for services of medical providers treating eligible members
- Administering its own program or contracting with an outside entity to do the administration

Medicaid programs, funded with both federal and state dollars, may vary considerably as individual states adapt the program to their unique populations. The federal government must certify states to operate a Medicaid Management Information System (MMIS) to be eligible for the full range of federal assistance. All branches of the IHCP use the same MMIS system for administration purposes. The Centers for Medicare and Medicaid Services (CMS) is the branch of the federal Department of Health and Human Services (HHS) that publishes guidelines for Medicaid, certifies an MMIS, and requires specific reporting designed to monitor each state's volume and expenditures for Medicaid. Both Medicaid and CHIP send state plans to CMS for review and approval.

All states certified to operate an MMIS must offer a specific range of services to Medicaid-eligible members and organize administration of the program following published guidelines. States are mandated to provide some categories of medical services and can provide other categories as optional services to their Medicaid enrollees. The following is a list of services provided by Indiana's program including most of the optional, as well as all of the required services that must be provided by a state's Medicaid program:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic (RHC) and federally-qualified health center (FQHC) services
- Clinical laboratory services
- Radiology services
- Long-term care services
  - Nursing home
  - Intermediate care facility for members with mental retardation (ICF/MR)
  - Mental hospital care for members younger than 21 years old or older than 65 years old
  - Community residential center for members with developmental disabilities (CFR/DD)
- Home health services
- Physician services
- Family planning services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs

- Transportation and ambulance services
- Pharmacy services
- Dental services
- Optometry services and eye glasses
- Medical supplies
- Durable medical equipment (DME), including surgical appliances and prosthetic devices
- Emergency room treatment – refer to *Section : Emergency Services*, for more detail regarding coverage.
- Physical therapy services
- Podiatry services
- Chiropractic services
- Community mental health rehabilitation services
- Occupational therapy services
- Respiratory therapy services
- Speech therapy services
- Audiological services and hearing aids
- Preventive health services
- Nurse practitioner services
- Nurse-midwife services
- Food supplements approved by the Food and Drug Administration (FDA)
- Psychiatric hospital services for individuals younger than 21 years old and older than 65 years old
- Psychiatric hospital services for individuals between 21 and 65 years old in psychiatric facilities of 16 beds or less
- Hospice services

In addition, the IHCP covers certain waiver services for a limited number of qualified members under one of the Home and Community-Based Services (HCBS) waiver programs.

All IHCP coverage is subject to certain limitations that may be defined in terms of the following:

- Specific services excluded from coverage (for example, cosmetic surgery)
- Limits on the frequency of services provided
- Services provided only under certain conditions (for example, prior-authorized services)
- Coverage available only to certain age groups of members
- Smoking cessation

State of Indiana Introducing Managed Care to Indiana Health Coverage Programs

Each state develops a state plan, which is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program, in accordance with federal and

state requirements. The Indiana requirements are contained in the *Indiana Code* (*IC*) and the *Indiana Administrative Code* (*IAC*). States can elect to administer the Medicaid program themselves or enter into contractual agreements with outside entities to administer the program. During the summer of 1994, the OMPP, under a federally-approved *Section 1915(b) waiver*, implemented a mandatory managed care program known as Hoosier Healthwise, which now includes both Medicaid and CHIP members. Indiana has contractual agreements with the following entities to support and administer the managed care component of the IHCP:

- Fiscal agent and premium collection vendor
- Medical policy and surveillance and utilization review (SUR) contractor
- Enrollment broker and Primary Care Case Management (PCCM) administrator
- Managed care organizations
- Monitoring contractor
- External quality review organization

The managed care component of Hoosier Healthwise is designed to meet the following goals:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Managed care in Hoosier Healthwise includes risk-based managed care (RBMC), which is comprised of the capitated MCO plans.

Risk-Based Managed Care

In a risk-based managed care delivery system, the OMPP pays contracted MCOs an actuarily sound capitated monthly premium for each IHCP enrollee in the MCO's network. The capitated premium covers the cost of care for services covered under the MCO program and incurred by IHCP enrollees in the MCO network. The MCO assumes financial risk for services provided to members in its network. The care of Hoosier Healthwise members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists, and other providers of care who contract directly with the MCO.

Member Choice

The Hoosier Healthwise enrollment broker provides information to aid the potential enrollee in the selection of an appropriate physician to meet the member's needs. There is emphasis on the importance of establishing and maintaining a relationship with a PMP of the member's choice. In addition, the information about the various networks is also discussed with the member in terms of the broad impact this choice has on the access to services other than primary care. Hoosier Healthwise member education as it relates to PMP selection is the responsibility of benefit advocates (BAs) hired by the State's enrollment broker. *Section 7: Member Eligibility and Enrollment* provides information about the member enrollment process.

Eligibility for Hoosier Healthwise Membership

The Hoosier Healthwise program provides health coverage to members in the general categories and benefit plans listed in Table 2.1.

Table 2.1 – Hoosier Healthwise Managed Care Benefit Package Information

Package	Eligible Members	Benefits
Standard plan – Package A	Children, low-income families, and some pregnant women	A full range of IHCP benefits
Pregnancy Coverage – Package B	Pregnant women with income below 150 percent of the Federal Poverty Level (FPL)	Pregnancy-related and postpartum care, urgent care, family planning, pharmacy, and transportation services
Children's Health Plan – Package C	Children younger than 19 years old in families with incomes from 150 to 200 percent of the FPL	Preventive, primary, and acute care

Enrollment in a managed care plan is **mandatory** for Hoosier Healthwise members in these broadly defined categories:

- *Temporary Assistance to Needy Families (TANF)* includes caretakers and children younger than 18 years old who meet eligibility requirements.
- *Pregnancy Medicaid* includes pregnant women who do not receive TANF. The full scope of benefits is available to women who meet strict income and resource criteria. Pregnancy-related coverage is provided to women whose income is below 150 percent of the FPL without regard to resources.
- *Children's Medicaid* includes children whose families do not receive TANF, but who are younger than 21 years old and meet the eligibility requirements.
- *Children's Health Insurance Program* (Phase 1 Medicaid expansion) became effective July 1, 1998, and includes children ages one to 19 years old in families with income up to 150 percent of the Federal Poverty Level (FPL) who are uninsured and otherwise ineligible for IHCP benefits.
- *Children's Health Insurance Program* (Phase 2 Hoosier Healthwise Package C) effective January 1, 2000, includes children ages zero to 19 years old in families with income greater than 150, but less than 200 percent of the FPL who are uninsured and otherwise ineligible for IHCP benefits. Unlike other categories of eligibility in Hoosier Healthwise, continued eligibility in Package C depends on payment of monthly premiums. Additional information about Package C is in *Section 12: Children's Health Insurance Program*.

Participation in a managed care plan is **voluntary** for members who are categorized as wards or foster children.

Enrollment Education

During the IHCP eligibility determination process, the enrollment benefit advocates (BAs) ensure that all enrollees eligible for managed care receive education and written materials about the following topics:

- The importance of PMP selection

- How to access care appropriately within the program, including appropriate use of the hospital emergency room
- The importance of primary and preventive care
- The differences between managed care and traditional fee-for-service IHCP coverage
- The unique characteristics of the MCO networks

BAs explain to potential enrollees that once they are eligible for the program, they have 30 days to choose a PMP.

Hoosier Healthwise encourages potential members to select a PMP who will provide, through an ongoing member-PMP relationship, preventive and primary medical care, as well as authorization and referral for all medically necessary specialty services. The PMP must be available 24 hours a day, seven days a week, and must assume total management of the member's non-emergent medical needs. A helpline, manned by the Hoosier Healthwise enrollment broker, is available for members to call with any problems or questions about the program. Helpline staff may refer the questions or problems to the appropriate entity for resolution.

Primary Medical Provider Eligibility in Hoosier Healthwise

A PMP is a physician operating in a primary care mode of practice in one of the following medical fields (provider specialty code):

- General practice (318)
- Family practice (316)
- General pediatrics (345)
- General internal medicine (344)
- Obstetrics and gynecology (328)

Primary care physicians in any setting are eligible to be PMPs and may serve any Hoosier Healthwise managed care member within the physician's scope of practice. Physicians practicing in a group setting may enroll to service Hoosier Healthwise members as a PMP within a particular group. Group enrollment does not necessitate PMP enrollment in Hoosier Healthwise. One group can contain physicians enrolled as PMPs in the Hoosier Healthwise program, as well as those who are not. Resident physicians in training are not eligible to serve as PMPs. All PMPs agree to be named in the Hoosier Healthwise provider listing.

Communication

Official IHCP policies are documented in the *IHCP Provider Manual* available to all providers enrolled in the IHCP and available online at http://www.indianamedicaid.com/. Supplements to this manual are distributed as needed. The following lists examples of some of the supplemental manuals:

- MCOs must publish provider manuals.
- The *HealthWatch (EPSDT) Provider Manual*, published and distributed by EDS, is sent to providers who meet the licensing requirements and who are interested in providing EPSDT services to the IHCP population. All Hoosier Healthwise PMPs are HealthWatch. The *IHCP Provider Manual* contains additional information about this program.

- IHCP provider bulletins and newsletters, published and distributed by EDS, are sent to providers to give policy updates. IHCP provider bulletins, available on the IHCP Web site at www.indianamedicaid.com, are normally distributed to providers affected by the policy addressed in the bulletin. For example, a change in the pricing methodology for home health care services is sent to those providers enrolled in the home health care provider specialty. By virtue of enrollment as IHCP providers, MCO network providers receive these communications based on the specialty under which they are enrolled in Indiana*AIM*. Bulletins are mailed to billing providers only. Provider newsletters are mailed to all enrolled IHCP providers each month. Newsletters are sent to billing providers only.
- Banner pages, published and distributed by EDS, are attached to the remittance advice (RA) sent to providers who have submitted claims to EDS for adjudication. Banner page articles are brief informational paragraphs and are available on the IHCP Web site, http://www.indianamedicaid.com/. Only providers who have submitted claims adjudicated by EDS receive banner pages and RAs.

To ensure consistency in program policy and operation, establishment of communication mechanisms for clarification of existing policy as well as discussion about new policy issues is critical. The following briefly describes the roles of the various entities responsible for the administration of the Hoosier Healthwise program. Each MCO must establish a central contact person within its organization who is primarily responsible for maintaining the communications with other organizations to resolve daily operational problems.

Enrollment Broker and PCCM Administrator

In addition to the responsibility of administration of the PCCM network, the enrollment broker serves as an unbiased source for member education about all aspects of the Hoosier Healthwise managed care program. The enrollment broker also facilitates initial member enrollment into the program, and performs member-initiated PMP changes and member disenrollment. MCOs also provide education to their members after enrollment in the MCO.

Fiscal Agent

EDS the fiscal agent for the IHCP, including Hoosier Healthwise, performs the premium collection for Package C, and is responsible for matters related to the development, maintenance, and operation of Indiana*AIM*. Major responsibilities include provider enrollment, claim adjudication, and payment to providers. EDS also generates monthly capitation payments and semimonthly enrollment rosters to the MCOs.

Medical Policy and Surveillance and Utilization Review

Health Care Excel, Inc. (HCE) is responsible for medical policy development for the IHCP. HCE assists in the development of medical policy for all IHCP fee-for-service components, administers prior authorization, and identifies potential overuse or fraudulent activity from program participants. MCOs must contact HCE with questions about IHCP medical policy and SUR issues.

Managed Care Organizations

The MCOs are prepaid health care delivery organizations. Please refer to Section 3 for additional information.

MCO Monitoring

Navigant Consulting assists the OMPP in monitoring MCO activity and performance. This ensures MCO compliance with contract requirements and performance standards.

EP & P Consulting, Inc. is the external quality review organization (EQRO). The EQRO performs an independent analysis of MCO performance in accordance with federal requirements at *42 CFR 438, Subpart E*.

Office of Medicaid Policy and Planning

The OMPP is the office within Indiana Family and Social Services Administration (IFSSA) that administers the IHCP, including Hoosier Healthwise. The OMPP has the final responsibility for Hoosier Healthwise managed care program contracting, setting all program policies, and coordinating with other state and federal agencies, as required.

Office of Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is a unit within the OMPP that administers the Phase 2 expansion of the IHCP as described in *Section 12: Children's Health Insurance Program*. The CHIP Unit coordinates with other state and federal agencies for this program and oversees premium collection.

Meetings

The following briefly describes the regularly-scheduled meetings that address policy and operational matters pertinent to the MCOs:

- *Managed Care Policy and Operations Meeting* – Daily operational matters and general questions are discussed among the managed care partners on an ongoing, informal basis. In addition, EDS facilitates a regular, structured meeting on the second Thursday of every other month to discuss new and ongoing program policy and operational issues. The current schedule is shown in *Appendix A: Managed Care Policy and Operations Meeting Schedule*.

  The meetings are a central forum to discuss issues relating to changes or clarifications in existing policy as well as creation of new program policy. The meeting participants are a core group of representatives from each entity contracted for Hoosier Healthwise. Participants can also include representatives from other organizations who may attend to address a specific agenda topic.

  Appendix A: Managed Care Policy and Operations Meeting Purpose and Structure defines the purpose and structure of the Policy and Operations meeting.

  Appendix B: Managed Care Policy Meeting Agenda Item Submission Form provides the topic submission format for agenda items to be presented. The presenter must submit items involving a policy discussion or decision to EDS by noon on Monday of the week preceding the scheduled meeting date. Items must be submitted in the required format. EDS will not include agenda items that are not submitted on the appropriate form.

  EDS sends the agenda, with all items to be discussed, to each organization approximately one week prior to the meeting. EDS also distributes meeting minutes to the meeting participants following each meeting.

- *MCO Technical Meeting* – EDS facilitates a meeting on the third Friday of each month to address technical issues of concern to the MCOs. This meeting is a central forum for discussion of issues related to data exchanges between the MCOs and the fiscal agent. Agenda item requests are to be submitted on the *MCO Technical Meeting Agenda Item Request Form* found in *Appendix D: Monthly MCO Technical Meeting Purpose and Structure*. EDS will not include agenda items not submitted on the appropriate form. Examples of issues discussed in this meeting are questions about the transmission or receipt of enrollment or capitation rosters, acceptance of shadow claim data into Indiana*AIM*, or other electronic interfaces. The purpose of this meeting is to provide assistance to MCOs who identify issues needing clarification. Agenda items for this meeting must be submitted to EDS one week prior to the meeting. On occasion, the fiscal agent or the OMPP may identify issues to be addressed in this forum. The meeting purpose, structure, and schedule are provided in *Appendix D: MonthlyMCO Technical Meeting Purpose and Structure.*
- *Quality Improvement Committee (QIC)* – Navigant Consulting facilitates the QIC meeting on the third Wednesday of each month to discuss quality improvement activities in the MCO. The QIC also establishes standards and guidelines for providing care and services within the Hoosier Healthwise program.
- *Clinical Studies* – Navigant Consulting facilitates the Clinical Studies meeting held the third Wednesday of each month. The purpose of this meeting is to develop, coordinate, and communicate clinical quality of care studies within the Hoosier Healthwise program.
- *Clinical Advisory Committee (CAC)* – The CAC has been mandated by *IC 12-15-33.5*. The CAC meeting occurs on the third Thursday of every other month. CAC membership consists of RBMC PMPs, MCO medical directors, and representatives from the Indiana State Department of Health (ISDH) and the OMPP. The purpose of the committee is to provide a forum for discussing and seeking clinical advice on program policies and operations.

Additional meetings the MCOs are required to attend include the Drug Utilization Review (DUR) Board meeting and the IHCP Medical Policy meeting. These meetings are not solely related to managed care policy and operations. See *Contract Attachment 1: MCO Scope of Work and Section 1.3* for OMPP meeting requirements.

MCO Meeting Requirements

The OMPP has an established set of meetings to discuss various aspects of the Hoosier Healthwise Managed Care Program. A schedule is released by the OMPP each year to identify meeting dates, times, and locations. In addition, an agenda is sent before each meeting with a copy of the previous month's meeting minutes.

The MCO must attend and participate in the following meetings. A description of each meeting is provided in the subsections that follow.

Managed Care Policy and Operations Meeting

Facilitator – EDS

Function – MCOs and other Hoosier Healthwise program contractors meet to discuss policies and current and future operational activities.

Frequency – Bimonthly meetings held in January, March, May, July, September, and November.

MCO Technical Meeting

Facilitator – EDS

Function – MCOs and the OMPP fiscal agent meet to discuss technical issues related to data systems information exchange.

Frequency – Monthly

Quality Improvement Committee

Facilitator – Navigant Consulting

Function – Attendees evaluate the effectiveness of QI activities of the MCOs. The QIC also establishes standards and guidelines for the provision of care and services within the Hoosier Healthwise program.

Frequency – Monthly

Clinical Studies (formerly known as Focus Study Workgroup)

Facilitator – Navigant Consulting

Function – MCOs and other Hoosier Healthwise program contractors develop, coordinate, and communicate clinical quality of care measures within Hoosier Healthwise. Measures can be State-designed studies or other approved Medicaid measures such as National Committee for Quality Assurance (NCQA's) Health Plan Employer Data and Information Set (HEDIS) measures.

Frequency – Quarterly

Hoosier Healthwise Clinical Advisory Committee

Facilitator – OMPP

Function – The CAC consists of at least seven and not more than 13 members, including seven licensed, practicing PMPs. The OMPP requires attendance by the MCO medical director or appropriate representative to represent the medical provider community providing services critical to the IHCP and Hoosier Healthwise population. The committee was established under *IC 12-15-22.5* to provide clinical insights and applications of clinical policy issues related to the following:

- Current standards of care
- Quality of care

Children's Health Policy Board

Facilitator – CHIP Office

Function – The Board was established under *IC 4-23-27* to provide policy direction for improving coordination of children's health programs in Indiana.

Frequency – Monthly

IHCP Medical Policy Meeting

Facilitator – Health Care Excel

Function – Processing of medical policies from initial evaluation through completion. Ongoing assessment of the implications of any changes to the IHCP and determination of the approach to changes. The IHCP medical policy meeting discussions encompass all IHCP medical policy decisions, including those that may or may not have an impact on the Hoosier Healthwise program.

Frequency – Quarterly

Drug Utilization Review Board

Facilitator – OMPP, Drug Utilization Review (DUR) Board Chairperson

Function – The DUR board was established under *IC 12-15-35* and is responsible for oversight of the retrospective and prospective DUR program. One of the DUR Board's duties includes the review and approval of formularies in the IHCP.

Frequency – Quarterly

Mental Health Quality Assurance Committee

Facilitator – Jeanne LaBrecque

Function – HEA 1325 confers upon the Mental Health Quality Assurance Committee (MHQAC) the responsibility to make recommendations to the Office of Medicaid Policy and Planning (OMPP) regarding access to behavioral health drugs through the Indiana Medicaid program. The office reports recommendations made by the committee to the Drug Utilization Review (DUR) board. OMPP has the ultimate responsibility for implementing any restrictions with the advice of the Committee.

Frequency – Monthly

The MCO is encouraged to attend but is not required to participate in the following meetings. A description of the meetings is provided in the subsections that follow.

IHCP Provider Workshops

Facilitator – EDS

Function – The OMPP, CHIP, and EDS provide Medicaid healthcare providers with information about the Medicaid program.

Frequency – Quarterly

- Accessibility of care
- Appropriateness of care
- Cost-effectiveness of care

Frequency – Bimonthly meetings held in January, March, May, July, September, and November.

Important Phone Numbers

Table 2.2 lists phone numbers for MCOs to call for general questions occurring during daily operations or in ongoing management activities. MCOs must make enrolled providers and members aware of the appropriate telephone numbers and educate them about their use. In addition to the numbers in Table 2.2, each PMP is required to have a 24-hour phone number for members. MCOs can take this responsibility by providing a nurseline for all their members. MCOs must update EDS and the OMPP whenever a provider or member services phone number is changed.

Table 2.2 – Important Telephone Numbers

Contact	Telephone Number	Hours of Operation	Description
EDS Automated Voice Response (AVR) System	(800) 738-6770 (317) 692-0819	5 a.m. to 1 a.m. EST daily	Member eligibility verification Other insurance information Benefit limits Prior authorization history
EDS Provider Enrollment	(317) 655-3240 (800) 577-1278	7:30 a.m. to 6 p.m. EST Monday – Friday	Enrollment in IHCP PMP enrollment questions
EDS Managed Care	(317) 488-5000	8 a.m. to 5 p.m. EST Monday – Friday	MCO general program or policy questions Indiana*AIM* questions Data exchange information. This number is for MCE, HCE, and OMPP use only. It must not be given to providers or members.
EDS Third Party Liability	(800) 457-4510 (317) 488-5046	7:30 a.m. to 6 p.m. EST Monday – Friday	Previous casualty coverage Previous lien information
Hoosier Healthwise Helpline	(800) 889-9949	8 a.m. to 6 p.m. EST Monday – Friday 8 a.m. to 12 EST Saturday	Member enrollment in Hoosier Healthwise Member PMP change requests Member education issues Member disenrollment from MCO PMP changes outside MCO network
OMPP Managed Care	(317) 233-8800	Regular business hours	MCO enrollment Marketing issues MCO monitoring Program performance Managed care contract procurement and evaluation
Navigant Consulting	(202) 973-2400	Regular business hours	Program monitoring and quality improvement
HCE Surveillance and Utilization Review	(317) 347-4500 Ext. 1248	Regular business hours	Identification and investigation of potential overuse or fraudulent activity from Program participants
HCE Medical Policy	(317) 347-4500 Ext. 1210	Regular business hours	Medical policy development
HCE Prior Authorization	(317) 347-4500 Ext. 1293	Regular business hours	Prior authorization process administration

MCOs may access http://www.indianamedicaid.com/ for additional IHCP contact telephone numbers.

MCO Member and Provider Helpline

Each MCO is required to establish and maintain a toll-free helpline for member and provider calls specific to MCO issues. *Section 6: Provider Services* provides detailed information about helpline requirements.

Section 3: Managed Care Organizations

Overview

Managed Care Orgnizations (MCOs) participating in Hoosier Healthwise collaborate with the Office of Medicaid Policy and Planning (OMPP) to provide quality care to program enrollees. While the core benefits identified in the Indiana Administrative Code (IAC) are provided under the MCO networks, the MCOs assume some of the responsibilities for enrolled members and providers that the State (or its designated contractor) performs for fee-for-service enrolled members and providers.

The following list, while not all-inclusive, highlights the major responsibilities of MCOs:

- Management of medical care for MCO-enrolled members
- Development and maintenance of a contracted provider network, including primary care physicians, specialists, hospitals, and ancillary providers of medical care
- Education of providers and members
- Maintenance of formal provider and member grievance processes
- Maintenance of member-specific encounter data transmitted to the State in fee-for-service equivalent detail (also known as shadow claims)
- Maintenance of a quality improvement and quality assurance program specific to the Hoosier Healthwise population
- Submission of required performance reports to the OMPP on a regular basis
- Maintenance of reimbursement arrangements with providers for services rendered to enrollees
- Provide and administer unique benefit packages to identified populations

Each of the MCO responsibilities is described in greater detail throughout this manual.

Eligible MCOs

An eligible MCO must comply with the following:

- Be a lawful entity authorized to operate a prepaid health care delivery plan (as a health maintenance organization (HMO)) under *IC-27-8-7-1*. If this statute is repealed, the MCO must be authorized under terms of its successor statute.
- Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the state.
- Contract with the State on a prepaid capitated basis to arrange, administer, and pay for the delivery of health care services to its members.

Participating MCOs have signed contracts with the state of Indiana and the OMPP. The OMPP selects MCOs through a competitive procurement process. Each MCO must submit a successful proposal to provide services to Hoosier Healthwise enrollees.

Each participating MCO is encouraged to attain accreditation from a recognized accrediting body such as the National Commission for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Staffing Requirements

The MCO must ensure all staff members have appropriate and ongoing training (such as orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, computer system, and so forth), education, and experience to fulfill the requirements of their positions. The MCO must institute mechanisms to maintain a high level of plan performance and data reporting capabilities regardless of staff vacancies or turnover. The MCO must have an effective method to address and reduce staff turnover (for example, cross training, use of temporary staff or consultants, and so forth) as well as processes to solicit staff feedback to improve the work environment. The MCO must maintain documentation to confirm its internal staff training, curriculum, schedules, and attendance.

The MCO must have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (for example, high school, college degree, and graduate degree), professional credentials (such as, licensure or certifications), direct work experience, and membership in professional or community associations.

The MCO must have an office in the state of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the plan's operations take place.

The MCO must employ key staff members listed below who are dedicated to the Hoosier Healthwise program. The key staff members include, but are not limited to the following:

- **Compliance Officer** – The MCO must employ a compliance officer who is dedicated full-time to the Hoosier Healthwise program. This individual is the primary liaison with the State (or its designees) to facilitate communications between the OMPP, the State's contractors, and the MCO's executive leadership and staff. This individual must maintain a current knowledge of federal and state legislation, legislative initiatives, and regulations that may impact the MCO's Hoosier Healthwise program. The OMPP must approve of the candidate who fills this position. The compliance officer, in close coordination with other key staff, has primary responsibility for ensuring all MCO functions are in compliance with the terms of the MCO's contract.
- **Management Information Systems (MIS) Coordinator** – The MCO must employ an MIS coordinator who is dedicated full-time to the Hoosier Healthwise program. This individual oversees the MCO's Medicaid MIS and serves as a liaison between the MCO and the State's fiscal agent, monitoring contractor, or other OMPP contractors about shadow claims submissions and other data transmission interface and management issues. The MIS coordinator, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the MCO's contract with the State. The OMPP must approve of the candidate who will fill this position.
- **Medical Director** – The MCO must employ or contract the services of a medical director who is an Indiana Health Coverage Program (IHCP) provider. The medical director must oversee the development and implementation of the MCO's clinical practice guidelines, review any potential quality of care problems, oversee the MCO's clinical management program, programs that address special needs populations, serve as the MCO's medical professional interface with the MCO's primary medical providers (PMPs) and specialty providers, be the point person for the MCO's disease management program for asthma and the Indiana Chronic Disease Management Program (ICDMP), and direct the quality management and utilization management programs, monitor corrective actions and other quality management, and monitor utilization management or program integrity activities. The medical director, in close coordination with other key staff members, is responsible for ensuring the medical management and quality management components of the MCO's operations are in compliance with the terms of MCO's contract with the State.

- **Member Services Manager** – The MCO must employ a member services manager who is dedicated full-time to the Hoosier Healthwise program. This manager must, at a minimum, be responsible for directing the activities of the MCO's member services, member helpline telephone performance, member education and outreach programs, and member materials development, approval and distribution, and serve as the primary interface with the State's fiscal agent and enrollment broker regarding such issues as member enrollment and disenrollment, member PMP changes, member eligibility, and newborn enrollment activities. This manager must provide an orientation and on-going training for member services helpline representatives, at a minimum, to support accurately informing members of how the MCO health plan operates, availability of covered services, benefit limitations, health needs assessment (HNA) screening, emergency services, PMP assignment, specialty provider referrals, self-referral services, preventive and enhanced services, well-child services, and member grievances and appeals procedures. The member services manager, in close coordination with other key staff members, is responsible for ensuring all of the MCO's member services operations are in compliance with the terms of the MCO's contract with the State.
- **Provider Services Manager** – The MCO must employ a provider services manager who is dedicated full-time to the Hoosier Healthwise program. This manager must, at a minimum, be responsible for monitoring the performance of the provider services helpline; monitoring provider recruitment, contracting, and credentialing; creating and updating provider manuals, education materials, and outreach programs; providing information to the OMPP or its contractors regarding the MCO's provider network; and facilitating the provider claims dispute process. The provider services manager, in close coordination with other key staff, is responsible for ensuring all of the MCO's provider services operations are in compliance with the terms of the MCO's contract with the State.
- **Quality Management Manager** – The MCO must employ quality management manager who is dedicated full-time to the Hoosier Healthwise program. The quality management manager must, at a minimum, be responsible for directing the activities of the MCO's quality management staff in monitoring and auditing the MCO's internal procedures to ensure a health care delivery system of the highest quality. This manager must assist the MCO's compliance officer in overseeing the activities of the MCO operations to meet the State's goal of providing health care services that improve the health status of the Hoosier Healthwise members.
- **Utilization Management Manager** – The MCO must employ a utilization management manager who is dedicated full-time to the Hoosier Healthwise program. This manager must, at a minimum, be responsible for directing the activities of the utilization management staff within the patient confidentiality guidelines mandated by the Health Insurance Portability and Accountability Act (HIPAA). This manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retro-review, continuity of care, care coordination, and other clinical and medical management programs.
- **Financial Officer** – A financial officer must oversee the budget and accounting systems of the MCO for the Hoosier Healthwise program. This officer must, at a minimum, be responsible for ensuring that the MCO meets the State's requirements for financial performance reporting.
- **Pharmacy Manager** – The MCO must employ a pharmacy manager dedicated full-time to the Hoosier Healthwise program. This individual will represent the MCO at the State's Drug Utilization Review (DUR) Board meetings, participate on the MCO's internal pharmacy therapeutics committee, and interface with the MCO's pharmacy benefits manager (PBM), the State's PBM and monitoring contractor. The pharmacy manager, in close coordination with other key staff, is responsible for ensuring all of the MCO's pharmacy operations are in compliance with the terms of the MCO's contract with the State.

The MCO must provide written notification to the OMPP's Managed Care Director of anticipated vacancies of key staff within five business days of receiving the key staff person's notice to terminate employment or five business days before the vacancy occurs, whichever occurs first. At that time, the

MCO must present the OMPP's Managed Care Director with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the MCO must notify the OMPP's Managed Care Director within five business days after a candidate's acceptance to fill a key staff position or five business days prior to the candidate's start date, whichever occurs first.

All key staff must be accessible to OMPP and its other program subcontractors via voicemail and electronic mail systems. As part of its annual quality management and improvement plan, the MCO must submit to the OMPP an updated organizational chart including e-mail addresses and phone numbers for key staff.

Drug Utilization Review Board

The Indiana DUR Board is appointed by the Governor to serve in an advisory capacity to Indiana Medicaid with regard to the prescription and dispensing of drugs by Medicaid providers and the use of drugs by Medicaid members. The DUR Board is composed of representatives of the pharmacy, medical, and scientific communities and has a responsibility to establish criteria for both retrospective review and prospective surveillance of drug prescription and dispensing for and use by Medicaid members. Through the expert opinion of the DUR Board members, aided, when appropriate, by consultants, the DUR Board provides the OMPP with advice on matters of drug usage so as to allow for the appropriate and cost effective delivery of medical and pharmaceutical care. For more information about the DUR Board refer to *IC 12-15-35-46*.

IC 12-15-35-47 provides that if a Medicaid MCO proposes to remove one or more drugs from the formulary (commonly referred to as the *preferred drug list (PDL*)) or places new restrictions on one or more drugs on the formulary, the MCO must submit the proposed changes to the OMPP for review and recommendation by the DUR Board. Therefore, the MCO must submit its proposed drug formulary, or any changes to its drug formulary after the OMPP has approved the MCO's drug formulary, to the OMPP at least 35 calendar days before it intends to implement or change its formulary.

The MCO must meet with the appropriate OMPP staff members to answer questions about clinical reasons for changes to the formulary. The OMPP will then forward the proposed formulary to the DUR Board for review and recommendation. The DUR Board will determine whether the proposed formulary impedes the quality of patient care in the Medicaid program or increases costs in other parts of the Medicaid program, including hospital costs and physician costs. Based on the recommendation of the DUR Board, the OMPP will approve, disapprove, or require modifications to the MCO's proposed formulary. During this process, the MCO must also be available to the DUR Board to respond to questions about the MCO's formulary. The DUR Board requires that the MCO submit a quarterly report as described in the *MCO Reporting Manual*, and the OMPP may require the MCO to submit additional reports to the DUR Board.

The Mental Health Quality Assurance Committee (MHQAC) has the responsibility to make recommendations to the Office of Medicaid Policy and Planning (OMPP) regarding access to behavioral health drugs through the Indiana Medicaid program. The office reports recommend ations made by the committee to the DUR board. The OMPP has the ultimate responsibility for implementing any restrictions with the advice of the MHQAC.

Financial

The OMPP and the Indiana Department of Insurance (IDOI) monitor MCO financial performance and require submission of financial reports on a quarterly basis.

Solvency

The MCO must maintain a fiscally solvent operation per federal regulations and IDOI requirements for a minimum net worth and set reserve amount. The MCO must have a process in place to review and authorize contracts established for reinsurance and third-party liability, if applicable.

The MCO must comply with the federal requirements for protection against insolvency pursuant to *42 CFR 438.116*, which require non-federally qualified MCOs to:

- Provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's debts if the entity becomes insolvent
- Meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity

Insurance

The MCO must be in compliance with all applicable insurance laws of the state of Indiana and the federal government throughout the term of the contract. No less than 90 calendar days prior to delivering services under this contract, the MCO must obtain from an insurance company duly authorized to do business in the state of Indiana, at least the minimum coverage levels for the following types of insurance:

- Professional liability (Malpractice) insurance for the MCO and its medical director, as defined in *IC 34-18-4-1*
- Workers' compensation insurance
- Comprehensive liability insurance
- Fidelity bond or Fidelity insurance, as defined in *IC 27-13-5-2*

The above insurance coverage must be maintained throughout the term of the contract. No fewer than 30 calendar days before the policy renewal effective date, the MCO must submit to the OMPP, its certificate of insurance for each renewal period for review and approval.

Reinsurance

The MCO must purchase reinsurance from a commercial reinsurer and must establish reinsurance agreements meeting the requirements listed below. New policies, renewals, or amendments must be submitted to the OMPP for review and approval at least 60 calendar days before becoming effective.

Agreements and Coverage

- The attachment point must be equal to or less than $125,000. The MCO electing to establish commercial reinsurance agreements with an attachment point greater than $125,000 must provide a justification in its proposal or submit justification to the OMPP in writing, and must receive approval from the OMPP before changing the attachment point.
- Reinsurance agreements must transfer risk from the MCO to the reinsurer.
- The reinsurer's payment to the MCO must depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.
- The MCO must receive reinsurance coverage of at least $2,000,000 per member per year.

- The MCO must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage must extend to members in acute care hospitals or nursing facility settings when the MCO's insolvency occurs during the member's inpatient stay. The MCO must continue to reimburse for its member's care under those circumstances (for example, inpatient stays) until the member is discharged from the acute care setting or nursing facility.

Requirements for Reinsurance Companies

- The MCO must submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.
- The MCO is required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of AA or higher and a Moody's bond rating of A1 or higher.
- If the MCO elects to self-insure, it must comply with the same provisions as required above for reinsurance companies.

Subcontractors

- Subcontractors' reinsurance coverage requirements must be clearly defined in the reinsurance agreement.
- Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.
- If subcontractors do not obtain reinsurance on their own, the MCO is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

Financial Accounting Requirements

The MCO must maintain accounting records specifically for performance of the Hoosier Healthwise contract that incorporate performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors. The MCO must maintain accounting records in accordance with the IDOI requirements. The MCO must provide documentation that its accounting records are compliant with National Association of Insurance Commissioners (NAIC) standards.

In accordance with *42 CFR 455.100-104*, the MCO must notify the OMPP of any person or corporation with five percent or more of ownership or controlling interest in the MCO and must submit financial statements for these individuals or corporations. Additionally, annual audits should include an annual actuarial opinion of the MCO's incurred but not received claims (IBNR) specific to the Hoosier Healthwise program.

Authorized representatives or agents of the state and the federal government must have access to the MCO's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance or retention period of this contract for purposes of review, analysis, inspection, audit, or reproduction. In addition, the MCO must file with the State Insurance Commissioner, the financial and other information required by the IDOI.

Copies of any accounting records pertaining to the contract must be made available by the MCO within 10 calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the MCO must provide transportation, lodging and subsistence at no cost, for all state and federal representatives to carry out their audit functions at the principal offices of the MCO or other locations of such records. The Indiana Family and Social Services Administration (IFSSA), the IDOI, and other state and federal agencies and their respective authorized representatives or agents must have access to all accounting and financial records of any

individual, partnership, firm, or corporation insofar as they relate to transactions with any department, board, commission, institution, or other state or federal agency connected with the contract.

The MCO must maintain financial records pertaining to the contract, including all claims records, for three years following the end of the federal fiscal year during which the contract is terminated, or when all state and federal audits of the contract have been completed, whichever is later, in accordance with *45 CFR 74.53*. Financial records should address matters of ownership, organization and operation of the MCO's financial, medical, and other record keeping systems. However, accounting records pertaining to the contract must be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract if the litigation has not terminated within the three-year period.

Reporting Transactions with Parties of Interest

The MCO, if not federally qualified, must disclose to OMPP information on certain types of transactions they have with a "party of interest" as defined in the *Public Health Service Act* (See *§§1903(m)(2)(A)(viii) and 1903(m)(4)* of the Act).

Definition of *A Party of Interest* – As defined in *§1318(b) of the Public Health Service Act*, a party of interest is:

- *Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;*
- *Any organization in which a staff member who is a director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;*
- *Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or*
- *Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.*

Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

- *Any sale, exchange or lease of any property between the HMO and a party in interest;*
- *Any lending of money or other extension of credit between the HMO and a party in interest; and*
- *Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.*

The information which must be disclosed in the transactions listed in subsection B between an MCO and a party in interest includes:

- *The name of the party in interest for each transaction;*
- *A description of each transaction and the quantity or units involved;*
- *The accrued dollar value of each transaction during the fiscal year; and*
- *Justification of the reasonableness of each transaction.*

The above information on business transactions must be accompanied by a consolidated financial statement for the MCO and the party in interest.

If the contract is an initial contract with the OMPP, but the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. If the contract is being renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported.

Subcontracts

The term *subcontract(s)* includes contractual agreements between the MCO and health care providers or other ancillary medical providers. Additionally, the term *subcontract(s)* includes contracts between the MCO and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the State MCO contract and any administrative entities not involved in the actual delivery of medical care. The State encourages the MCO to subcontract with entities that are located in the state of Indiana.

Subcontractor agreements do not terminate the legal responsibility of the MCO to the State to ensure that all activities under the contract are carried out. The MCO must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the MCO's monitoring activities. The MCO is held accountable for any functions and responsibilities that it delegates.

If the MCO holds subcontracts with another prepaid health plan, physician-hospital organization or other risk baring entity that accepts financial risk for services the MCO does not directly provide, the MCO must monitor the financial stability of the subcontractor(s) with payments equal to or greater than five percent of premium/revenue. The MCO must obtain the following from the subcontractor quarterly:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Incurred but not reported (IBNR) estimates

Annually, the MCO must obtain from the subcontractor: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity or fund balance, and an actuarial opinion of the IBNR estimates. The MCO shall make these documents available to the OMPP upon request.

The MCO must comply with *42 CFR 438.230* and the following subcontracting requirements:

- The MCO must obtain the approval of the OMPP and the IDOA before subcontracting any portion of the project's requirements. The MCO must give the OMPP a written request at least 60 calendar days prior to the use of a subcontractor. If the MCO makes changes to the subcontractor contract, it must notify the OMPP 60 calendar days prior to the revised contract effective date.
- The MCO must evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the Hoosier Healthwise program.
- The MCO must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is

inadequate. The written agreement must be in compliance with all state of Indiana statutes, and is subject to the provisions thereof.

- The MCO must collect performance and financial data from its subcontractor's and monitor delegated performance on an ongoing basis and conduct formal, periodic, and random reviews, as directed by the OMPP. The MCO must incorporate all subcontractors' data into the MCO's performance and financial data for a comprehensive evaluation of the MCO's performance compliance and identify areas for its subcontractors' improvement when appropriate. The MCO must take corrective action if deficiencies are identified during the review.
- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. The MCO must comply with all subcontract requirements specified in *42 CFR 438.230*. All subcontracts, provider contracts, agreements or other arrangements by which the MCO intends to deliver services must be subject to review and approval by the OMPP and must be sufficient to assure the fulfillment of the requirements of *42 CFR 434.6*. In accordance with *IC 12-15-30-5(b)*, subcontract agreements for Hoosier Healthwise business terminate when the MCO's contract with the State terminates.

Debarred Individuals

In accordance with *42 CFR 438.610*, the MCO must not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under *Executive Order No. 12549* or under guidelines implementing *Executive Order No. 12549*
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in this chapter

The relationships include directors, officers, or partners of the MCO, persons with beneficial ownership of five percent or more of the MCO's equity, or persons with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the State.

In accordance with *42 CFR 438.610*, if the OMPP finds that the MCO is in violation of this regulation, the OMPP will notify the Secretary of noncompliance and determine if the agreement will continue to exist.

Section 4: Managed Care Services

Covered Services in Risk-Based Managed Care

Services covered by Managed Care Organizations (MCOs) and reimbursed by capitation payments for members enrolled in MCO networks must be furnished in an amount, duration, and scope that is no less than those Indiana Health Coverage Programs (IHCP)-covered services detailed in *405 IAC 5*, in accordance with *42 CFR 438.210*. Services covered by the IHCP for MCO members, but excluded from the MCO's scope of responsibility, called carve-outs, are itemized in this section. Detailed explanations of Medicaid-covered services and limitations are cited in *405 IAC 5*, CHIP (Package C) in *407 IAC 3.*

The following lists broad categories of services provided by the MCO network in an MCO arrangement with the Office of Medicaid Policy and Planning (OMPP):

- Physician services
  - Primary care services
  - Preventive health services (including vaccinations added to the periodicity schedule but not yet available through the Vaccines for Children program)
  - Therapeutic and rehabilitative services
  - Specialty care services
- Hospital services
  - Inpatient care
  - Outpatient services
  - Therapy services
  - Laboratory and X-ray services
  - Diagnostic studies
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
  - Initial and periodic screenings
  - Diagnosis and treatment
- Home health services
  - Physical, occupational, and respiratory therapy
  - Speech pathology
  - Renal dialysis
- Pharmacy services
  - Legend drugs
  - Non-legend drugs (selected over-the-counter drugs) as identified in the OMPP over-the-counter formulary
  - Insulin, nutritional and food supplements, and infant formulas
- Medical supplies and equipment
  - Medical supplies and durable medical equipment
  - Braces and orthopedic shoes
  - Prosthetic devices
  - Hearing aids
- Transportation services
  - Emergency transportation
  - Nonemergency transportation
  - Transportation to and from services provided by the MCO

  - Transportation to and from services excluded from MCO capitation but covered by IHCP under fee-for-service, otherwise known as carved out services
- Diabetes self management services
- Pregnancy care coordination
- HIV and AIDS targeted case management services
- Smoking cessation services
- Behavioral health services rendered by providers other than mental health specialists; for example, PMPs and acute care hospitals, require a referral from the member's PMP or authorization from the MCO. The Hoosier Healthwise program requires that the member's MCO reimburse providers for behavioral health services when providers other than mental health specialists (such as, physicians and acute care hospitals) render behavioral health services. Behavioral health services, including mental health, substance abuse and chemical dependency services, rendered by mental health specialty providers enrolled in the IHCP are by State law self-referral services. Behavioral health services rendered by mental health providers are also carved out of the MCO responsibility. The State's fiscal agent, on a fee-for-service basis, reimburses the mental health specialty providers for behavioral health services. The mental health provider specialties are:
  - Psychiatric hospitals
  - Outpatient mental health clinics
  - Community mental health clinics
  - Psychiatrists
  - Psychologists
  - Certified psychologists
  - Health services providers in psychology
  - Certified social workers
  - Certified clinical social workers
  - Psychiatric nurses
  - Independent practice school psychologists
  - Advanced practice nurses under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Special provisions regarding specific types of service, coverage and payment policies apply to some services and providers, include the following; and are discussed later in this section
  - Emergency services
  - Out-of-plan services
  - Out-of-area services
  - Self-referral services
  - FQHC and RHC services
  - Hospital extended stay for children investigated by protective services
  - Services related to carved out services
  - Short term placements in long-term care facilities
  - Continuity of care
  - Women, Infants, and Children program(WIC) infant formula

Emergency Services and Post-Stabilization Care Services

MCOs are responsible for providing or reimbursing for 24-hour emergency care for Hoosier Healthwise members. This coverage must be extended to out-of-state and out-of-network facilities that provide emergency services to an MCO's Hoosier Healthwise enrollees.

MCOs must pay for emergency services without requiring authorization for such services, in accordance with the federal *Balanced Budget Act of 1997* (*BBA*), Medicaid Managed Care rules (*42*

CFR Part 438), and *House Enrolled Act 1872* (*IC 12-15-12*). MCOs are responsible for covering and reimbursing emergency services, including medically-necessary screening services provided to members who present themselves to an emergency department with an emergency medical condition. Payment for these services provided by an out-of-network hospital must be equal to the IHCP rate in effect on the date of service.

The criteria used to define an emergency medical condition must be consistent with the prudent layperson standard and in compliance with all applicable state and federal requirements. MCOs can approve coverage on the basis of a code such as an International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code. However, payment for emergency services cannot be denied only on the basis of codes. The determination of whether the prudent layperson standard is met is made on a case-by-case basis.

In accordance with *42 CFR 438.114*, the MCO may not determine what constitutes an emergency on the basis of lists of diagnosis codes or symptoms. The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical condition, even if the outcome, in absence of immediate medical attention, would not have been those specified in the definition of an emergency medical condition.

MCOs are financially responsible for post-stabilization care services for their members under the following conditions:

1. The services are pre-approved by a representative of the member's MCO;
2. The services are not pre-approved but are administered to maintain the enrollee's stabilized condition within one hour of a request for pre-approval of further post-stabilization care services; or
3. The services are not pre-approved but are administered to maintain, improve, or resolve the enrollee's stabilized condition if any of the following occur:
   a. The MCO representative does not respond to a request for pre-approval within one hour
   b. The MCO representative cannot be contacted
   c. The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a physician representing the MCO is not available for consultation.

If the situation described in 3.c. above exists, the MCO gives the member's treating physician an opportunity to consult a physician representing the MCO. The treating physician may continue to care for the member until a physician representing the MCO is reached or until one of the following criteria is met:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the member's care through transfer.
- The MCO and treating physician reach an agreement concerning the member's care.
- The member is discharged.

Out-of-Area Services

The MCO member may obtain some services out of the MCO contracted region. The MCO is responsible for payment of emergency and self-referral services obtained by its members from out-of-area providers. Except for self-referral services, MCO members must obtain authorization from the MCO to receive non-emergency services out-of-area. The MCO can deny payment to an out-of-area provider except as previously described. Out-of-area providers must be enrolled in IHCP to receive reimbursement.

Out-of-Plan Services

In addition to out-of-plan emergency services previously described, MCOs are responsible for coverage and payment of all authorized routine care provided out of the established network. An MCO must authorize and pay for necessary services to an IHCP enrolled but out-of-network provider or facility when appropriate providers or facilities are not available within the MCO network. Additionally, MCOs must reimburse out-of-plan providers for member self-referral services as listed in the *Self Referral* subsection. These providers must be IHCP enrolled.

MCOs must follow the claims processing and interest provisions of *IC 12-15-13* for all out-of-network provider claims for which they are responsible. To be reimbursed for services rendered to a Hoosier Healthwise member, out-of-network providers must be IHCP enrolled. Reimbursement for out-of-network claims must be based on the IHCP fee schedule in effect on the date of service, unless there is a different fee arrangement between the out-of-network provider and the MCO.

Self-Referral Services

Federal and state regulations allow members access to certain services outside of the network in which they are enrolled without a referral. Capitation amounts include payment for the *self-referral* services listed below. Hoosier Healthwise members can receive self-referral services from any IHCP-enrolled provider qualified to provide the service, whether or not the provider belongs to the same network as the member. MCOs are responsible for ensuring that the self-referral services are covered and authorized in advance in accordance with *405 IAC 5*. The following are self-referral services in Hoosier Healthwise risk-based managed care (RMBC):

- Services rendered for the treatment of an emergency medical condition, as defined in the *42 CFR 438* and *IC 12-15-12*
- Family planning services
- Chiropractic services
- Podiatric services
- Eye care services (except eye care surgeries)
- HIV and AIDS targeted case management services
- Diabetes self management services rendered by a chiropractor, podiatrist, optometrist, or psychiatrist outside the MCO network or to an IHCP-enrolled provider as a referral from one of these provider specialties
  - Behavioral health services, including mental health, substance abuse and chemical dependency services, rendered by mental health specialty providers.
- Members may access **emergency services** on a self-referral basis as described under *Emergency Services* in this section. To be reimbursed by the IHCP or the MCOs, the facility must be enrolled in the IHCP.
- Members may access **family planning services** from any IHCP-enrolled provider qualified to render the service. Family planning services are defined by procedure and diagnosis code combinations detailed in a supplement to the *IHCP Provider Manual* and in *Appendix E: Family Planning Services.*
- The Centers for Medicare and Medicaid Services (CMS) interprets family planning services to include birth control pills. The member must be allowed to obtain birth control pills on a self-referral basis from providers and pharmacies out of the MCO network. The OMPP recognizes the need for appropriate management of prescription medication in the interest of the member's health and also recognizes the importance of removing barriers to family planning services. To reduce

family planning barriers, MCOs must reimburse, in one dispensing, a minimum of a 90-day supply of birth control pills per member, if prescribed. The OMPP encourages MCOs to reimburse transportation to the pharmacy for periodic refills of birth control pills to further assist members with family planning services.

- **Chiropractic services** are defined as IHCP-covered services rendered by a provider enrolled with a specialty 150 (chiropractor) and practicing within the scope of the chiropractic license.
- **Podiatric services** are defined as IHCP-covered services rendered by a provider enrolled with a specialty 140 (podiatrist) and practicing within the scope the medical license.
- MCO members can seek most **vision care services** on a self-referral basis from IHCP providers enrolled with vision care specialties 180 (optometrist), 190 (optician), or 330 (ophthalmologist) and practicing within the scope of their licenses. MCOs can require that vision-related surgeries be provided in the network when available. The following ranges of Current Procedural Terminology (CPT®) codes define vision-related surgeries:
  - 65091-65114 – Removal of eye and related procedures
  - 65125-65175 – Ocular implants and related procedures
  - 65205-65265 – Removal of foreign body from eye (unless billed with an emergency diagnosis code)
  - 65270-65290 – Repair of laceration and related procedures
  - 65400-66999 – Procedures on anterior segment including cornea, anterior chamber, anterior sclera, iris, lens, and cataract removal
  - 67005-67299 – Procedures on posterior segment including vitreous, retina, sclera
  - 67311-37999 – Procedures on ocular adnexa including orbit, eyelids, brow, and related procedures
  - 68020-68899 – Conjunctiva and related procedures
- ***HIV/AIDS Care Coordination*** services are billed using the primary diagnosis code 042 – HIV/AIDS and the national Healthcare Common Procedure Code System (HCPCS) procedure code G9012. The MCO is expected to work with the HIV/AIDS care coordinator to avoid duplication of services with any case management services provided by the MCO. HIV/AIDS care coordination claims are not subject to managed care edits; therefore, there is no requirement for a PMP's certification code and provider number on the paper CMS-1500 claim form or the 837P transaction. Additional information about this waiver program, authorized by *42 USC 1396n(g)* and administered by the Indiana State Department of Health (ISDH), is located in the *IHCP Provider Manual*.

  HIV and AIDS care coordination is a specialized form of case management for members with HIV infection. Care coordination consists of goal-oriented activities that locate or create, facilitate access to, coordinate, and monitor the full range of HIV-related health and human services. The purpose is to encourage the cost-effective use of medical and community resources and to promote the well being of the individual while assuring the individual's freedom of choice. To assure freedom of choice, the individual signs a *Freedom of Choice/Intent to Participate Form* acknowledging an understanding of the services provided and identifying the chosen care coordination provider. Care coordination services are those that assist Medicaid-eligible people in the targeted group to access needed medical, psychological, social, educational, and other services.
- ***Diabetes Self-Management Training Services*** are available to Hoosier Healthwise members on a self-referral basis from any chiropractor, podiatrist, optometrist, or psychiatrist outside the MCO network who has had specialized training in the management of diabetes. MCOs can require that diabetes self-management training services from other qualified health care professionals be provided within the MCO network. MCOs can also require members to obtain prior approval for payment to out-of-network providers. Specific information about this benefit is provided in Indiana Medicaid Update *E98-05* and *405 IAC 5-36*.

- ***Behavioral health services*** rendered by mental health providers are also carved out of the MCO responsibility. The State's fiscal agent, on a fee-for-service basis, will reimburse the mental health specialty providers for behavioral health services. For more information on the behavioral health carve-out see *IHCP Covered Services Excluded from RBMC* in this section.
  - Psychiatric hospitals
  - Outpatient mental health clinics
  - Community mental health clinics
  - Psychiatrists
  - Psychologists
  - Certified psychologists
  - Health services providers in psychology
  - Certified social workers
  - Certified clinical social workers
  - Psychiatric nurses
  - Independent practice school psychologists
  - Advanced practice nurses under *IC 25-23-1-1(b)(3*), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

Services Related to Self-Referral Services

MCOs are financially responsible for charges related to self-referral services described above including pharmacy fees, facility charges, and professional fees. If an MCO is notified that a procedure or service is being provided as a self-referral procedure, the MCO can manage the care by requesting the provider use network facilities. If the self-referral provider uses facilities out of the MCO's network, the MCO must reimburse the facility and ancillary providers for medically necessary services at IHCP rates. For example, if a podiatrist renders a service in an out-of-network ambulatory surgical center (ASC), the MCO is required to reimburse the out-of-network facility for the charges related to the self-referral procedure at IHCP rates.

MCOs are responsible for medically necessary expenses for pharmacy services related to self-referrals incurred by members, whether or not the prescribing physician or dispensing pharmacy is in the MCO network.

Payment for Self-referral Services

MCOs may negotiate reimbursement rates paid for self-referral services to providers who have contractual relationships with the MCO and are enrolled in the IHCP. When MCO-enrolled members choose providers for self-referral services outside the MCO network, the MCO is responsible for payment to these providers according to the established IHCP fee schedule at the rates in effect on the date of service.

MCOs follow the claims processing and interest provisions of *IC 12-15-13* for all out-of-network or non-contracted provider claims for which they are responsible. This includes out-of-network claims for self-referral services and any other services rendered by non-contracted providers. The MCOs are responsible for reporting to the OMPP the data regarding out-of-network claims and the interest payments associated with the claims. See the *MCO Reporting Manual* for specifics on reporting requirements.

Federally Qualified Health Centers and Rural Health Clinics

MCOs contract with the federally-qualified health centers (FQHCs) and rural health clinics (RHCs) to ensure that FQHCs and RHCs are reimbursed for services at a rate comparable to other providers and sufficient enough to operate economically viable and efficient facilities.

The OMPP provides a supplemental payment, at least quarterly, to the FQHC or RHC to bring reimbursement up to 100 percent of reasonable costs based on data provided by the FQHC or RHC. To calculate the supplemental payment, the amount paid by the MCO directly to the FQHC or RHC for services provided to MCO members is subtracted from 100 percent of their reasonable costs.

Annually, MCOs must submit to the OMPP the amount paid by the MCO to each FQHC or RHC for services provided to MCO members, so that the OMPP can perform the annual reconcilation. The results of the reconciliation will determine whether additional payments are made to the clinic or if recoupment is needed.

The MCO must identify for the State all the financial incentives offered to the FQHC. All incentives accrued during the contract period relating to the cost of providing FQHC-covered or RHC-covered services to MCO members must be included along with any fee-for-service and capitation payments in the determination of the amount of direct reimbursement paid by the MCO to the FQHC or RHC. Specifics about the FQHC and RHC reports are in the *MCO Reporting Manual.*

Extended Hospital Stays for Children Investigated by Protective Services

If an MCO in the Hoosier Healthwise program is the health care plan for a child subject to investigation of abuse or neglect, the MCO is required to provide payment for extended hospital stays mandated by state law *IC 31-33-11, subsections a* and *c,* which states the following:

Section 1.a

(a) Whenever:

a child is subject to investigation by a local child protection service for reported child abuse or neglect;

the child is a patient in a hospital; and

the hospital has reported or has been informed of the report and investigation;

The hospital may not release the child to the child's parent, guardian, custodian, or to a court approved placement until the hospital receives authorization or a copy of a court order from the investigating local child protection service indicating that the child may be released to the child's parent, guardian, custodian, or court approved placement.

(c)The individual or third party payor responsible financially for the hospital stay of the child remains responsible for any extended stay under this section. If no party is responsible for the extended stay, the division of family and children shall pay the expense of the extended stay.

IHCP-Covered Services Excluded from Risk-Based Managed Care

Exclusions

Broad categories of service, covered by the IHCP but excluded from managed care, are payable as fee-for-service claims by IHCP's fiscal agent. If a managed care member becomes eligible for any of these services the member will be disenrolled from managed care. Services excluded from managed care include:

- Long-term institutional care
- Hospice care

- Waiver services

MCO members who qualify for long-term institutional care, hospice care, or waiver services are disenrolled from their Hoosier Healthwise managed care plan according to the member disenrollment criteria outlined in *Section 7: Member Eligibility and Enrollment.* MCOs must note that it is possible for a member's Indiana Pre-Admission Screening/Pre-Admission Screening and Resident Review (IPAS/PASRR) process to be underway (but not yet complete) when the member is linked to an MCO. In this situation, the financial responsibility lies with the MCO for no more than 60 days.

Carve-outs

There are other broad categories of service excluded from the capitation payment for an MCO's enrolled membership but included in the managed care benefit package. These services are called *carve-outs*. While the MCO retains responsibility for the delivery and payment of most care for its members, *carve-outs* remain the financial responsibility of the State and are reimbursed as fee-for-service claims under the fiscal agent contract. The following services are carved out of capitation:

- Mental health, substance abuse, and chemical dependency services (behavioral health services) rendered by providers enrolled in IHCP with a mental health specialty. Specialties include; psychiatric hospital, outpatient mental health clinic, community mental health clinic, psychiatrist, psychologist, certified psychologist, health services provider in psychology, certified social worker, certified clinical social worker, psychiatric nurse, independent practice school psychologists, and advanced practice nurses credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center. Services related to the treatment of substance abuse or chemical dependency are included in IHCP's mental health benefit. Mental health and substance abuse services provided in an acute level facility or rendered by the PMP remain the financial responsibility of the MCO.
- As stated in *405 IAC 5-20-8* and the *IHCP Provider Manual*, the IHCP reimburses physician or HSPP-directed outpatient mental health services for group, family, and individual psychotherapy when services are provided by one of the following mid-level practitioners.
  - Academy of Certified Social Workers (ACSW)
  - Certified Clinical Social Worker (CCSW)
  - Advanced practice nurses under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric
  - Certified psychologist or mental health nursing by the American Nurses Credentialing Center
  - Licensed Clinical Social Worker (LCSW)
  - Licensed independent practice school psychologists
  - Licensed mental health counselor
  - Licensed marriage and family therapist
  - Licensed psychiatric and mental health clinical nurse specialist
  - Psychologist with a basic certificate
  - A person holding a master's degree in social work, marital and family therapy, or mental health counseling.
  - RN with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing
  - These mid-level practitioners may not be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. Reimbursement is available for services provided by mid-level practitioners in an outpatient mental health facility when services are supervised by a physician or HSPP. Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. The appropriate procedure code should be

billed in conjunction with one of the following modifiers to indicate the type of mid-level practitioner providing the service.
  - AH – Services provided by a clinical psychologist
  - AJ – Services provided by a clinical social worker
  - HE in conjunction with SA – Services provided by a nurse practitioner or clinical nurse specialist
  - HE – Services provided by any other mid-level practitioner as addressed in the *405 IAC 5-25*
  - HW – Medicaid Rehabilitation Option (MRO) services
  - Claims billed for mid-level practitioner services with these modifiers will be reimbursed at 75 percent of the IHCP allowed amount for the procedure code identified.
  - Additional information along with these billing procedures can be found in Chapter 8 of the *IHCP Provider Manual*.

- Dental services from providers enrolled in an IHCP dental specialty and billed on a dental claim form. Specialties include endodontist, general dentistry practitioner, oral surgeon, orthodontist, pediatric dentist, periodontist, mobile dentists, prosthodontist, and dental clinics. CMS-1500 claims and UB-92 claims submitted by dental providers and oral health services provided by non-dental specialists (for example, anesthesiology) are not included in this carve out and shall continue to be submitted to the appropriate MCO.
- Services provided by a school corporation as part of a student's individualized education plan (IEP). The MCOs must coordinate with the schools.
- Services provided by the State's First Steps program. The MCOs must coordinate with First Steps.

Services in the categories previously listed are generally excluded from the capitation payments based on the provider type and specialty of the billing provider. For example, a claim for an office visit billed by a psychiatrist with a diagnosis of depression for an MCO-enrolled member is submitted and considered for payment as a fee-for-service claim. A claim for an office visit billed by the member's PMP with a diagnosis of depression is submitted to the MCO and reimbursed according to the MCO PMP financial arrangement. Other services that are the responsibility of the MCO regardless of diagnosis include: services categorized earlier but provided by the PMP, acute care hospital, or ambulatory surgical center.

Services Related to Carve-Out Services

Services related to the carved out services remain the financial responsibility of the MCO. Examples of related services include pharmacy, transportation, ambulatory surgical center (ASC), and acute care hospital expenses that may have been incurred by the member during a course of treatment. Pharmacy and ASC expenses incurred in relation to a covered dental procedure for example, remain the financial responsibility of the MCO, even though the MCO may not be liable for the primary procedure. Similarly, the MCO retains financial responsibility for pharmacy and other related expenses incurred in conjunction with outpatient mental health care treatment.

If an MCO is notified that a carve-out service will be provided, the MCO can attempt to manage the care by requesting that a provider use the MCO network facilities and other ancillary providers. If the provider uses out-of-network facilities, the MCO must reimburse the facility and ancillary providers for medically necessary services at IHCP rates.

Short-Term Placements in Long-Term Care Facilities

An MCO may allow its enrolled members to receive services in a nursing or long-term care (LTC) facility on a short-term basis (no more than 30 days) if this setting is more cost-effective than other options and if the member can obtain the care and services needed.

The MCO is financially responsible for the short-term placement fees made to the nursing facility at the IHCP fee-for-service rate or at a rate negotiated with the facility. If the short-term stay is extended beyond 30 days, the screening must be completed within 25 days after the end of the short-term stay (except as specified for Pre-Admission Screening and Resident Review cases). A member approved for long-term nursing facility placement is disenrolled from the Hoosier Healthwise managed-care plan and converted to fee-for-service eligibility in the IHCP at the time the appropriate level of care (LOC) information is entered in Indiana*AIM*. The MCO plays a critical role in monitoring its members who are receiving care in a nursing facility and helping coordinate the transition to long term care. The MCO is not responsible to pay for more than 60 days of nursing facility care. See information about pending LOC in this section.

An important responsibility of the nursing facility is to complete the *Physician Certification of Long Term Care Service, Form 450B*, indicating that the member has entered the nursing facility. The OMPP LOC Unit, upon receipt of the *Form 450B* indicating a short-term stay, enters an LOC indicator of **M** into Indiana*AIM*. The **M** indicator prevents fee for service payments from being generated for these short-term placements.

Continuity of Care

MCOs may receive member enrollments, through member selection or auto-assignment, for patients who have ongoing medical care provided by hospitals, specialists, or ancillary providers. The Hoosier Healthwise program is committed to providing continuity of medical care during a member's transition period into the program or between networks within Hoosier Healthwise. The MCO is financially responsible for providing medically necessary care during the transition from another network into the MCO's network. Some examples of the need for special consideration include, but are not limited to, the following:

- Pregnant members who enter Hoosier Healthwise in the third trimester of pregnancy
- Newborn children of MCO members retroactive to the date of birth
- Members who are hospitalized on the effective date of Hoosier Healthwise
- Members who have a prior authorization issued by another Hoosier Healthwise network that is still open on the effective date with the new Hoosier Healthwise network
- Members undergoing the Indiana Pre-Admission Screening/Pre-Admission Screening and Resident Review (IPAS/PASRR) process for long-term care placement
- Members in the third trimester of pregnancy at the time they enter an MCO network may continue to receive prenatal, delivery, and postpartum care from their previous physicians. When the member notifies the MCO that she wishes to maintain the existing relationship for the duration of the pregnancy, the MCO contacts the doctor to confirm the existing relationship and arrange for payment of services to the out-of-network provider.
- The MCO arranges for and reimburses covered services provided to newborn children of MCO members from the newborn's date of birth. The MCO remains responsible for out-of-network services from the date of birth until eligibility in a different network can be verified in the eligibility verification system (EVS).

EDS cannot control when newborn eligibility is transmitted from the State's eligibility system, Indiana Client Eligibility System (ICES), to Indiana*AIM*. There may be delays of several weeks to several months before EDS can send newborn eligibility to MCOs due to delays in transmissions from ICES to Indiana*AIM*. Therefore, MCOs must be aware of pregnant mothers enrolled in their network.

- Hoosier Healthwise members may change or be assigned to a new managed care network or fee-for-service with an effective date in the new network during the course of an inpatient stay. Such a change necessitates the coordination of medical care and payment responsibilities between the affected networks. The network in which the member was enrolled on the day of admission to a facility reimbursed on a diagnosis related grouping (DRG) basis is responsible for the DRG payment. DRG payments are not prorated between networks if a member's eligibility changes during the course of an acute care hospitalization. Hospital charges reimbursed on a per diem basis are prorated between the networks according to the member's eligibility by date of service during the hospitalization. MCOs are required to reimburse out-of-network providers when a change in eligibility occurs during an inpatient hospitalization. Authorization personnel from each network must notify the new network when they become aware of a change in networks during the course of the hospitalization, allowing the new network to review the care plans and complete the discharge planning. Charges for professional services provided during the course of the hospitalization are the responsibility of the network in which the member was enrolled on the date of service.

Outstanding Prior Authorizations

At the time members enter or change a Hoosier Healthwise network, they may have received authorizations for services or procedures that were not completed on the effective date of the enrollment into a new network. The prior authorizations may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care. Requiring a duplicate authorization from the new network places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services to the Hoosier Healthwise member. Health plans participating in Hoosier Healthwise must honor outstanding prior authorizations given for services within the IHCP (whether Hoosier Healthwise managed care or traditional fee-for-service) for the first 30 days of a member's effective date in the new network. This authorization extends to any service or procedure previously authorized within the Hoosier Healthwise program, including but not limited to surgeries, therapies, pharmacy, home health care, and physician services. MCOs may be required to reimburse out-of-network providers during the 30-day transition period.

The entity that issued the original prior authorization provides the new network with the following:

- Member identification number (RID)
- IHCP provider number
- Procedure codes
- Duration and frequency of authorized services
- Other information pertinent to the determination

This information can be provided in spreadsheet format, computer screen prints, authorization form copies, or any other mutually agreed upon format.

Hoosier Healthwise Members Pending Level of Care Determination

The long term care (LTC) facility, such as nursing facility, Community Residential Facility for the Developmentally Disabled (CRF/DD), or Intermediate Care Facility for the Mentally Retarded (ICF/MR) where an IHCP member is treated must verify the patient's IHCP eligibility and health care

program when the patient is admitted or screened, to determine whether the individual is currently enrolled in a managed care program. The facility must contact the managed care plan responsible for the patient's care.

If the eligibility information indicates that the patient is enrolled in RBMC, the LTC provider must contact the MCO identified by the EVS. The provider must verify the patient's IHCP eligibility, not only upon admission and screening, but also on the first and 15th of every month thereafter because the member may switch from fee-for-service Medicaid to a managed care health plan.

If a managed care member is undergoing screening for admission to an IHCP-certified LTC or nursing facility, the facility must complete the level of care (LOC) paperwork and submit it to the appropriate agency. During the time that the facility or appropriate agency is processing the paperwork, the member may be auto-assigned to a PMP in a managed care plan. It is not until the LOC determination is entered into Indiana*AIM* that managed care enrollment is blocked or managed care disenrollment occurs. Additional information about this process can be found in Chapter 14 of the *IHCP Provider Manual*. Chapter 14, Section 12 covers the managed care related issues.

If the facility determines that a patient is enrolled in a Hoosier Healthwise MCO, the provider must notify the MCO within 72 hours. If the provider fails to verify an IHCP member's coverage or fails to contact the MCO within 72 hours of admission, the provider is responsible for any charges incurred until the Hoosier Healthwise member is disenrolled from the MCO. When the provider notifies the MCO within 72 hours of admission, the MCO is liable for charges up to 60 days. If the provider fails to complete the paperwork for the appropriate LOC determination and the member is still enrolled in Hoosier Healthwise after two months, the MCO is no longer liable for payment. However, as long as the patient is a member of the MCO, claims submitted to EDS are denied payment.

WIC Infant Formula

For Medicaid-covered nutritionals that are covered by WIC, the MCO is **not** the payer of last resort. The MCO must not deny these types of claims because the member has other insurance.

Disease Management

The MCO must have an asthma disease management program for eligible Hoosier Healthwise members. The OMPP reserves the right to require the MCO to have additional disease management programs. Some example of programs include diabetes or childhood obesity. Other programs may be defined by the OMPP. The OMPP will provide 12 months advanced notice to the MCO if it decides to add new diseases to the disease management program requirements.

Provision of Enhanced Services

In conjunction with the provision of covered services, MCOs are strongly encouraged to provide programs and benefits intended to enhance the general health and well being of members and provide greater access to care. For example, transportation to and from a pharmacy is an enhanced service that provides greater access to care. Wellness programs available to the MCO's commercial population must be made available to its Hoosier Healthwise enrollees. Additionally, the MCO is encouraged to provide enhanced services, such as health education classes, that target the IHCP population specifically. The MCO must inform the OMPP at least four weeks prior to implementation or provision of any enhanced services. The OMPP reviews these enhanced services and the MCO must receive OMPP approval prior to implementation. The enhanced services must comply with the marketing and other relevant guidelines provided in this manual. Any type of incentives used to market an outreach or education program must be approved in advance by the State, and they cannot

have a retail value of more than ten dollars individually. The annual maximum for member gifts or incentives is $50 per member. Under no circumstances are monetary incentives to be offered or used.

Member Financial Resposibility

Co-payments

Certain services such as transportation, non-emergency use of the emergency room, and pharmacy may be subject to a member co-payment. Pregnant women and children are not subject to co-payment requirements and cannot be charged any co-payments or other cost-sharing fees. *Section 12: Children's Health Insurance Program* provides detailed information about benefits available to Package C members that are subject to co-payments. Providers can not refuse to see members based on the member's inability to pay the co-payment.

Charging Hoosier Healthwise Members for Services Rendered

IHCP providers are prohibited from billing an IHCP member or the member's family for any amount billed but not paid by IHCP for a covered service. Providers must accept IHCP reimbursement as payment in full for the services rendered.

There are limited instances in which a provider can charge an IHCP member for services. Services not covered by the IHCP, such as cosmetic procedures or services that have been denied through the prior authorization process, can be billed to the member if the provider receives and retains the member's signed statement accepting financial responsibility for the services. This statement must be specific about the services to be billed; must be signed by the member prior to receiving the services; and must be retained as documentation in the patient's medical record. *Section 6: Provider Services* gives additional information about member billing.

Chapter 4, Section 5 of the *IHCP Provider Manual* contains additional information about member billing.

Section 5: Member Services

Member Information Materials

The Managed Care Organization (MCO) must establish policies and procedures to ensure that materials are accurate in content, accurate in translation, relevant to language or alternate formats, and do not defraud, mislead, or confuse the member. The MCO must develop and include an MCO-designated inventory control number on all member promotional, education, or outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate the Office of Medicaid Policy and Planning's (OMPP's) review and approval of member materials and document its receipt and approval of original and revised documents. The MCO must keep a log of all member materials used during the year. The MCO must also submit its member handbook to the OMPP annually for review. The *MCO Reporting Manual* details the member materials reporting requirements.

The MCO must produce member materials and may only distribute member materials approved by the OMPP and comply with *42 CFR 438.10*. The MCO must provide information for use in member education and enrollment, upon request by the State or the State's designee. This information may include, but is not limited to, the following:

- A provider directory listing the MCO's providers in its network and identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access, and other demographic information in accordance with *42 CFR 438.10(f)(6)(i)*
- MCO member bulletins or newsletters issued not fewer than three times a year that provide updates related to covered services, access to providers
- Updated policies and procedures specific to the Hoosier Healthwise population
- MCO telephone system scripts and commercials-on-hold
- MCO-distributed literature about all health or wellness programs that the MCO offers
- MCO's marketing and promotional brochures and posters
- A member handbook that describes the terms and nature of services offered by the MCO and contact information including the MCO's Internet Web site address

General Information Requirements

The MCO must make written information available in English and Spanish and other prevalent non-English language, as identified by the OMPP, upon the member's request. In addition, the MCO must identify additional languages that are prevalent among members. The MCO must inform members that information is available upon request in alternative formats and how to obtain alternative formats. The OMPP defines alternative formats as Braille, large font letters, audiotape, prevalent languages, and verbal explanation of written materials.

To the extent possible, written materials must not exceed a fifth grade reading level. The MCO must provide notification to its members of the Hoosier Healthwise-covered services that the MCO does not elect to cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with *42 CFR 438.102*. The MCO must provide this information to the member before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service. The MCO must inform the members that, upon the member's

request, the MCO will provide information on the structure and operation of the MCO and, in accordance with *42 CFR 438.6(h)*, will provide information on the MCO's provider incentive plans.

The MCO is responsible for developing and maintaining member education programs designed to provide the members with clear, concise, and accurate information about the MCO's program, the MCO's network, and the Hoosier Healthwise program. The State encourages the MCO to incorporate community advocates, support agencies, health departments, other governmental agencies, and public health associations in its outreach and member education programs. The State encourages the MCO to develop community partnerships with these types of organizations to promote health and wellness within its Hoosier Healthwise membership. The MCO's educational activities and services should also address the special needs of specific Hoosier Healthwise subpopulations (such as, pregnant women, newborns, early childhood, at-risk members, and children with special needs) as well as its general membership. The MCO must demonstrate how these educational interventions reduce barriers to health care for members. The MCO must review its education and outreach program activities in the annual *Quality Management and Improvement Plan Summary Report*.

Web site

The MCO must provide information to members through a user-friendly Internet Web site in a OMPP-approved format (currently Bobby format) to ensure compliance with existing accessibility guidelines that is available to members, providers and the community within six months of the effective date of the MCO's contract with the State. More information about the Bobby format is available at: http://bobby.watchfire.com/bobby/html/en/index.jsp. The OMPP must preapprove the MCO's Web site information and graphic presentations. The Web site information must be accurate and current, culturally appropriate, written for understanding at a fifth grade reading level, and available in English and Spanish. The MCO must inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the Web site must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The MCO must date each Web page, change the date with each revision, and allow users acess to print the information. Such Web site information should include, but not be limited to, the following:

- The MCO's provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access, and other demographic information. The MCO must update the online provider network information monthly at a minimum.
- The MCO's contact information for member inquiries, member grievances, or appeals
- The MCO's member services phone number, Telecommunications Device for the Deaf (TDD) number, hours of operation, and after-hours access numbers
- The MCO's wellness and prevention programs or prenatal services (particularly if these are enhanced beyond standard Hoosier Healthwise coverage)
- A description of the MCO's chronic disease management programs
- The member's rights and responsibilities
- The member handbook
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement
- The MCO's preferred drug list and in-network pharmacy locations
- Transportation access information
- Information about how to access carved-out services

- A list and brief description of each of the MCO's member and provider outreach and education materials
- The executive summary of MCO's *Annual Quality Management and Improvement Program Plan Summary Report*

The MCO must submit all marketing, promotional, educational, and outreach materials to the OMPP for review and approval at least 30 calendar days prior to expected use and distribution. Additionally, the MCO must receive the OMPP's approval to use or display the Hoosier Healthwise logo each time the MCO wishes to do so (for example, the MCO should not assume the OMPP's approval for use of the logo based on any previous approvals). The MCO must receive approval from the OMPP prior to distribution or use of materials. The OMPP reserves the right to assess liquidated damages or other remedies for the MCO's non-compliance in the use or distribution of any non-approved member materials.

Handbook

Upon enrollment in the MCO program, the MCO must provide members with a handbook containing written policy that includes information on the following:

- Rights and responsibilities of the members
- Benefits and services included and excluded as a member of the MCO program and how to obtain them
- Special benefit provisions (for example, co-payments, deductibles, limits, or rejection of claims) that may apply to services obtained outside of the MCO network
- Procedures for accessing in-network services
- Procedures for obtaining out-of-area services
- Provisions for 24-hour access to care, including emergency care
- Standards and expectations to receive preventive health services
- MCO policy on referrals to specialty care
- Procedures for notifying members affected by termination or change in any benefits, services, or service delivery sites
- Procedures for appealing decisions adversely affecting the members' coverage, benefits, or relationship with the MCO
- Procedures for changing PMPs
- Procedures for changing plans within Hoosier Healthwise
- Procedures for making complaints, filing grievances, and recommending changes in policies and services

Education, Outreach, and Marketing Materials

All education, outreach, and marketing materials must meet the following guidelines:

- The State must approve all education and outreach materials, including materials of MCO subcontractors, prior to distribution. The State reserves the right to assess liquidated damages for any violations of this requirement.
- All materials must be on health and wellness issues pertaining to the Hoosier Healthwise program.

- The OMPP must review and approve any materials that use the Hoosier Healthwise logo prior to distribution, for each material use. The MCO must cooperate with the OMPP to identify which materials require the program logo. The OMPP's decision on use of the logo is final.
- All brochures, presentation materials, and information packets must follow the standards established by the OMPP. All materials must be written at a fifth grade reading level or lower and be culturally appropriate. Materials submitted to the State for approval must indicate the measurement used to assess the reading level (such as, SMOG, FOG, or other method) and must have the reading level indicated.
- Any educational, outreach, or marketing materials must be distributed within the entire service area specified by the MCO and approved by the OMPP.
- Marketing materials cannot contain any false or misleading information and must be approved by the OMPP before distribution.
- Literature about health and wellness promotion programs offered by the MCO is encouraged.

The OMPP will not approve materials if it determines that the content is inaccurate, misleading, or otherwise misrepresents the program. It will not approve materials if they do not directly deal with health care issues. The materials must be culturally sensitive to the population groups served by the MCO.

The contents of education, outreach, and marketing materials must not refer to or identify the addressee as a Hoosier Healthwise or Medicaid enrollee and must include, at a minimum:

- Information about how the individual can receive additional information or contact an MCO representative with questions
- Information about who to call if a member is hearing impaired or needs an interpreter

The MCO must provide the OMPP written notification immediately upon discovery of an alleged or suspected marketing violation by marketing representatives. Upon notification, the OMPP investigates with the MCO's cooperation. The MCO must take appropriate action and is subject to loss or restriction of enrollment, marketing privileges, or other suitable remedy.

Member Education

Pre-enrollment

In accordance with *42 CFR 438.10 (e)*, the enrollment broker must provide the following MCO information, at a minimum, to the member prior to the selection of the PMP and the enrollment in the MCO network:

- List of PMPs, specialists, and hospitals within the Hoosier Healthwise network produced and distributed by the enrollment broker. This list must include general information, including area of specialty, telephone number, practice limitations, whether new patients are currently being accepted, and any restrictions on the scope of practice (for example, non-English language spoken)
- MCO-specific information such as service area cost sharing, enhanced services, wellness programs, and so forth

Post-enrollment

The MCO is responsible for the development and maintenance of member education and outreach programs. These programs are designed to provide the member with information about the MCO's services. MCO member bulletins or newsletters specific to the Hoosier Healthwise population are to be issued not fewer than three times a year. These publications must provide updates related to covered services, access to providers, and updated policies and procedures. The MCO is encouraged to provide literature about health and wellness programs offered by the MCO. The OMPP must review and approve newsletters prior to distribution like other education and outreach materials.

An MCO's educational activities and services must focus on the special needs of its Hoosier Healthwise population. MCOs must demonstrate how these educational interventions would reduce barriers to health care for members.

MCOs must make post-enrollment information available to members. This information includes but is not limited to the following:

- Summary of IHCP-included and excluded benefits and services, as well as any enhanced services available in the MCO network
- Statement that most necessary health care services, except long-term institutional care, hospice care, behavioral health services, dental services, and services provided by a school corporation as part of a student's Individualized Education Plan (IEP) are provided through the MCO and must be obtained through the MCO facilities or providers
- Statement that all self-referral services (services rendered for the treatment of an emergency, family planning services, chiropractic services, podiatric services, eye care services other than eye surgeries, HIV and AIDS targeted case management, and diabetes self-management services) can be obtained either in or out of the MCO network. *Section 4: Managed Care Services* contains additional information about self-referral services.
- Description of the MCO's 24-hour access to emergency care procedures
- Information about member's rights and responsibilities under the MCO's plan, including participation in member satisfaction surveys
- Information about grievance procedures and the rights of a member with respect to the filing of a grievance
- Information about the member's right to change PMPs and the procedures for disenrollment from the MCO
- Information about preventive health programs or enhanced services offered by the MCO

Member Grievance Procedures

As required by *42 CFR 438(f)*, each MCO must have a formal grievance process approved in writing by the OMPP for promptly reviewing and resolving grievances and appeals brought by its members. The process must comply with *IC 27-13-10* and *IC 27-13-10.1* and follow the OMPP-approved grievance and appeals process. *Appendix K* contains additional information about Indiana's Hoosier Healthwise member inquiry, grievance, and appeal process.

MCO Member Helpline

The MCO must maintain a statewide toll-free telephone helpline for members with questions, concerns, or complaints. The MCO must staff the member services helpline to provide sufficient live voice access to its members during (at a minimum) a ten-hour business day, Monday through Friday. The member services helpline must offer language translation services for members whose primary language is not English and must offer telephone-automated messaging in English and Spanish. A member services messaging option must be available after business hours in English and Spanish and member services staff must respond to all member messages by the end of the next business day.

The MCO must provide TDD services for hearing impaired members. The MCO must establish telephonic capability to transfer calls and connect the member to the State's enrollment broker whenever appropriate (for example, to facilitate the member's changing to another PMP). The MCO must maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The MCO must monitor its member services helpline service and report its telephone service performance to the OMPP each month as described in the *MCO Reporting Manual*.

The MCO's member services helpline staff must be prepared to respond to member concerns or issues including, but not limited to the following:

- Access to health care services
- Identification or explanation of covered services
- Special health care needs
- Procedures for submitting a member grievance or appeal
- Quality of care

Upon a member's enrollment in the MCO, the MCO must inform the member about the member services helpline. The MCO should encourage its members to call the MCO member services helpline as the first resource for answers to questions or concerns about Hoosier Healthwise, PMP issues, benefits, MCO policies, and so forth.

Member to Provider Communications

The MCO must not prohibit or restrict a health care professional from advising a member about his or her health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the Hoosier Healthwise program, as long as the professional is acting within his or her lawful scope of practice. This provision does not require the MCO to provide coverage for a counseling or referral service if the MCO objects to the service on moral or religious grounds.

In accordance with *42 CFR 438.102(a)*, the MCO must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits, and consequences of treatment or non-treatment.

The MCO must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The MCO may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Marketing

Marketing Activities

The OMPP permits and encourages the MCO and its subcontractors to promote their services to the general community, but forbids direct outreach or direct marketing to potential Hoosier Healthwise managed care members and Hoosier Healthwise enrollees who are not the MCO's members. In accordance with *42 CFR 438.104*, the MCO cannot conduct, directly or indirectly, door-to-door, telephone or other cold-call marketing enrollment practices. The MCO may not directly outreach or market to a Hoosier Healthwise enrollee prior to the enrollee becoming a member in the MCO's program.

The prohibition on MCO outreach to Hoosier Healthwise managed care members applies equally to enrollees who apply for the program at a Division of Family Resources (DFR) office or at any other outstation location. The MCO may not offer gifts, incentives, or other financial or non-financial inducements greater than $10 for each individual and $50 per year, per individual. The MCO is subject to penalties under the *Social Security Act Section 1128A(a)(5)* about inducements, remunerations, and gifts to Medicaid and Package C members. The MCO must comply with all marketing provisions in *42 CFR 438.104*, and federal and state regulations about inducements and must itemize its marketing gifts, incentives, and other financial inducements annually in the *Quality Management and Improvement Plan Summary Report.*

All member outreach, marketing, and education materials must be submitted to the OMPP for approval prior to distribution and in accordance with OMPP policy. Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, at a fifth grade reading level, and must not be misleading or designed to confuse or defraud members or potential members. Examples of false or misleading statements include, but are not limited to:

- Any assertion or statement that the member or potential member must enroll in the MCO to obtain benefits or to avoid losing benefits
- Any assertion or statement that the MCO is endorsed by the Centers for Medicare and Medicaid Services (CMS), the federal or state government, or a similar entity

The MCO cannot entice a potential member to join the MCO by offering the sale of any other type of insurance as a bonus for enrollment, and the MCO must ensure that a potential member can make his or her own decision as to whether to enroll.

The MCO may provide (at its own cost, including any costs related to mailing) an informational brochure or flyer to the State's enrollment broker for distribution to potential Hoosier Healthwise enrollees at the time of PMP selection. The MCO may submit promotional material for poster-sized (11" X 17") to the OMPP for approval. The MCO must submit a promotional materials distribution plan to the OMPP in January of each year. Upon approval of the plan, the MCO can make these posters available to the local county office of Family Resources and enrollment centers for display in an area where Hoosier Healthwise application or member enrollment occurs. Each local county office of Family Resources and enrollment center may display these promotional materials at its discretion. The MCO may display these same promotional materials at community health fairs or other outreach activities. The OMPP must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

If the MCO wishes to use the Hoosier Healthwise logo, the MCO must request approval from the OMPP for each desired use. Any approval given for logo use is specific to the use requested, and shall not be interpreted as a blanket approval.

Marketing Violations

Violations can include, but are not limited to, discrimination, misleading or attempting to defraud either members or the OMPP, harassment of eligible members, and other practices deemed to be objectionable. In accordance with *42 CFR 438, Subpart I*, the OMPP may take whatever corrective actions are deemed necessary under individual circumstances, including but not limited to:

- Freezes on MCO enrollment
- Exclusion of MCO from auto-assignment
- Suspension of payment

If the OMPP monitoring or investigation indicates that marketing staff or the MCO has violated any provision contained in this document, the OMPP can require the MCO to provide documentation including the following:

- Copies of any or all correspondence sent to members regarding the alleged marketing violations
- Internal memos
- Written notification of any action taken against the alleged offending marketing staff
- Written plan of correction
- Revisions to marketing presentations or marketing plans

Copies of any communications related to the matter with Indiana Department of Insurance (IDOI)

Section 6: Provider Enrollment

Overview

All providers rendering services to Hoosier Healthwise members in a risk-based managed care (RBMC) network must be enrolled in the Indiana Health Coverage Programs (IHCP), including out-of-state providers. Providers must also agree to comply with all IHCP regulations and State standards for access to care and quality of services. The Managed Care Organization (MCO) must submit model provider contracts to the Office of Medicaid Policy and Planning (OMPP) for approval prior to use.

The MCO, through its network of PMPs and other providers, is responsible for providing or authorizing reimbursement of most primary and preventive care services. These services include:

- Physician services
- Hospital inpatient and outpatient services
- Ancillary services, including but not limited to, pharmacy, X-ray, laboratory, and radiology, therapies, HealthWatch Early Periodic Screening Diagnosis and Treatment (EPSDT), audiology, home health care, and durable medical equipment (DME) and supplies, except as explicitly carved out from the responsibility of the MCO

The MCO must provide education and enrollment services for the health care provider network, ensure proper maintenance of medical records, maintain proper staffing to respond to provider inquiries, and be able to process provider claim disputes and appeals. A written plan must be updated quarterly detailing methods of provider recruitment, education, and outreach regarding MCO policies and procedures. The State must approve all education and outreach materials designed for distribution to enrolled providers.

MCO Enrollment

After the execution of a contract between Indiana Family and Social Services Administration (IFSSA) and the MCO, the IFSSA submits a written request to the fiscal agent (EDS) to enroll the MCO in Indiana*AIM*. This notification includes the MCO name, address, contact name, telephone number, electronic funds transfer (EFT) information, electronic claim submission (ECS) information, tax information, and negotiated capitation rates by region.

On verification of the required information, EDS enrolls the MCO in Indiana*AIM* and sends confirmation letters to the IFSSA and the MCO. The letters contain the MCO's unique identification number comprised of nine digits and one alphabetic character (999999999X). The alphabetic character denotes the region of the state in which the MCO is enrolled (North, Central, South). If the MCO is enrolled in more than one region, the ID number remains the same, with only the alphabetic character changing for each service region.

Provider Education, and Outreach Activities

The MCO must develop a work plan that includes the plans to educate primary medical providers (PMPs), specialists, subcontractors, hospital providers, and ancillary providers, including provider staff, about the Hoosier Healthwise program and the MCO policies and procedures. The plan must specify the providers identified for training, as well as specific positions within the MCO that are responsible for the education and outreach activities. The plan must include time frames needed to

complete education and outreach sessions and the target audience (primary medical providers, hospital providers, subcontractors, ancillary providers, and so forth).

The quarterly education and outreach work plan must include an educational packet approved by the OMPP. The packet must include a notification letter to those attending a particular education and outreach session. The notification letter must include the time, date, and location of the session, session agenda, and appropriate handouts.

Policies and procedures outlining education and outreach activities must also include the frequency at which these training sessions will occur. A plan for improvement as a result of increased inquiries and complaints from providers must also be incorporated in these policies to assist with ongoing educational efforts.

Provider Credentialing and Recredentialing Policies and Procedures

The following subsections provide the provisions dealing with credentialing and recredentialing are a summary of current National Committee for Quality Assurance (NCQA) standards. MCOs must refer to the NCQA standards for further detail.

Credentialing

The MCO must have credentialing procedures to determine whether physicians and other health care professionals under contract with the MCO are licensed by the State and are qualified to deliver health care services.

The MCO must have written policies and procedures for credentialing health care professionals it employs and with whom it contracts. These health care professionals include chiropractors and podiatrists. The MCO must have documented plans to periodically review and revise policies and procedures. If the MCO contracts with a hospital that conducts the MCO's credentialing activity, the MCO must have access to the hospital credentialing files. At minimum, the MCO must obtain and review verification of the following:

- A current valid license to practice
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility
- Current and valid Drug Enforcement Administration (DEA) or controlled substance registration (CSR) certificate, as applicable (DEA certificates are not applicable to chiropractic settings)
- Proof of graduation from medical school and completion of a residency, or board certification for medical doctors (MDs) and doctors in osteopathy (DOs), as applicable since the last time the provider was credentialed or recredentialed
- Proof of graduation from chiropractic college for doctors of chiropractic medicine (DC)
- Proof of graduation from podiatry school and completion of residency program for doctors in podiatric medicine (DPMs)
- Work history that includes a minimum of five years on the curriculum vitae (the MCO is not required to verify work histories)
- Current, adequate malpractice insurance according to the MCO's policies

- History detailing any pending professional liability claims, as well as claims resulting in settlements or judgments paid by or on behalf of the practitioner
- Proof of board certification if the practitioner states being board certified
- Verification of IHCP enrollment. If group enrollment, verify that the provider is linked appropriately to the group, and verify that the provider is enrolled at the appropriate service locations

The credentialing policies and procedures must specify the professional criteria required to participate in the MCO. Each practitioner file must contain sufficient documentation to demonstrate that these criteria are evaluated. Primary sources used by the MCO to verify credentialing information must be included in its policies and can include use of external agencies such as county medical societies, hospital associations, or private verification services.

Mechanisms for Credentialing and Recredentialing

The MCO must document the mechanism for credentialing and recredentialing MDs, DOs, DPMs, and DCs that fall under the MCO's scope of authority and action, and with whom it contracts or employs to treat members outside the inpatient setting. This documentation includes but is not limited to the following:

- The scope of practitioners covered
- The criteria and the primary source verification of information used to meet these criteria
- The process used to make decisions
- The extent of any delegated credentialing or recredentialing arrangements

Policies and procedures must specify the requirements and the process used to evaluate practitioners. Selection decisions must be based on the network needs of the MCO, as well as practitioners' qualifications. Selection decisions cannot be based solely on a practitioner's membership in another organization, such as a hospital or medical group.

Policies and procedures must include physicians and other licensed independent practitioners who are subject to these policies, as well as criteria to reach a decision.

The MCO must have a process in place for receiving advice from participating practitioners in credentialing and recredentialing to ensure that procedures are followed consistently. MCOs must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.

Participating practitioners must complete an application for membership on such a committee. Through the application process, the practitioner discloses information about health status and any history of issues with licensure or privileges that may require additional follow-up. A signed attestation statement on the application ensures that the practitioner has completed it in good faith.

Before making a credentialing decision, the MCO must have the following information on the practitioner:

- Information from the National Practitioner Data Bank (NPDB). NPDB is not applicable to chiropractors and podiatrists
- Information about sanctions or limitations on licensure from the State Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations, if available

- Information from the State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards
- Information from the State Board of Podiatric Examiners
- Previous sanction activity by Medicare and the IHCP

Evidence indicating that the MCO has obtained information from the previously designated organizations must be included in the credentialing file.

Credentialing – Initial Visit

The MCO credentialing process must include an initial visit to the offices of all potential primary medical providers including all OB/GYNs. There must be a structured review that evaluates the site against the MCO standards. The initial site visit must also include documentation of the evaluation of the medical record-keeping practices at each site to ensure conformity with the maintenance of medical records. *Section 5: Member Services* outlines this documentation.

Recredentialing

The MCO must have a formal recredentialing process that verifies the credentialing information subject to change over time. The recredentialing process must be organized to verify the information through a primary source on the current standing of items listed in this section, such as member complaints, quality reviews, utilization management, and member satisfaction. The description of the recredentialing process must include data from at least three of the following six sources:

- Member complaints
- Quality reviews (practice-specific)
- Utilization management (profile of utilization)
- Member satisfaction (practice-specific)
- Medical record review
- Practice site reviews

The recredentialing evaluation process must use this data as objective evidence in the reappraisal of professional performance, judgment, and clinical competence. There must be evidence that the MCO has taken action based on the data. Examples of action taken include continuation in the MCO, required participation in continuing education, required supervision, a clear plan for improvement with the practitioner, evidence of changes in the scope of practice, or termination of the practitioner from the MCO.

Recredentialing Practice Site Visit

The MCO must conduct an on-site visit at the time of recredentialing to determine if there have been any changes in the facility, equipment, staffing, or medical record-keeping practices that would affect the quality of care or services provided to members of the MCO. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit. The MCO is responsible for determining which high-volume specialists are subject to this visit, based on its own experience with the specialist.

Altering Conditions of Provider Participation

MCOs must have plans for developing and implementing policies and procedures for altering conditions of a provider's participation with the MCO due to issues of quality of care and service. These policies and procedures need to specify actions the MCO may take before terminating the provider's participation with the MCO. Policies and procedures must have mechanisms in place for reporting serious quality deficiencies to the OMPP that could result in a provider's suspension or termination. These policies and procedures must specify how reporting occurs and the individual staff members responsible for reporting deficiencies.

The policies and procedures must include a well-defined appeals process for instances in which the MCO decides to alter the provider's condition of participation as a result of quality of care or service issues. The MCO must ensure providers are aware of the appeals process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

Credentialing Provider Health Care Delivery Organizations

The MCO must have policies and procedures for credentialing health care delivery organizations, including but not limited to, hospitals, home health agencies, freestanding surgical centers, laboratories, and subcontracted networks of providers.

Every three years after the initial contract the MCO must confirm the following:

- That the organizations are in good standing with state and federal regulatory bodies
- That the organizations have been reviewed and approved by an accreditation body before contracting with the MCO
- That the organizations conform to the previously mentioned requirements

The MCO must also develop standards of participation and assess these providers accordingly if the provider has not received accreditation.

Clinical Laboratory Improvement Amendments

MCOs must arrange for laboratory services only through those laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

Provider Service Locations

PMPs can designate no more than two service locations that accept Hoosier Healthwise assignments. **Physicians must be IHCP enrolled at these service locations before they can designate them as PMP service locations.** Physicians can download IHCP applications from the IHCP Web site at http://www.indianamedicaid.com/. MCOs must verify that the physician is IHCP enrolled prior to submitting a PMP enrollment to the EDS Managed Care enrollment specialist. PMPs can treat Hoosier Healthwise members at any enrolled service location, but receive member enrollment or auto-assignment at only two locations. PMPs participating in an MCO can have service locations in any Indiana county that the MCO's state contract allows.

Out-of-State Providers

During the first two years of Hoosier Healthwise, only physicians with an office location in Indiana, licensed to practice in the state, and enrolled as providers in the IHCP were permitted to enroll as PMPs in Hoosier Healthwise. To enhance access to primary care in areas with an inadequate number of PMPs, the OMPP now permits out-of-state PMPs to enroll in the program in areas where limited access has been identified. Concurrent with the implementation of the program statewide effective July 1996, the OMPP developed criteria to determine which areas would most benefit from additional PMPs with out-of-state locations, permitting these enrollments on a case-by-case basis according to predetermined access measures. PMPs with out-of-state service locations are available for voluntary selection by members. Out-of-state PMPs are not included in the auto-assignment process.

Residency Programs

To promote long-term relationships for Hoosier Healthwise members, physicians practicing in group residency programs are not eligible to enroll as PMPs in the Hoosier Healthwise program. The frequent turnover of physicians in a residency program disrupts the continuity of care essential to a managed care program. Residents can provide care to Hoosier Healthwise members only if the residency program's faculty physicians are participating PMPs and are enrolled in Indiana*AIM* in the same billing group as the resident physicians. The PMP or faculty physician retains responsibility for the care provided to Hoosier Healthwise patients and must provide oversight to the resident physician consistent with the residency program's stated procedures.

Hoosier Healthwise members are linked to the supervising physician as the PMP of record and the IHCP eligibility systems provide that doctor's name as the PMP on the eligibility verification system (EVS).

School-based Clinics

Some Hoosier Healthwise members are eligible for and receive medical services in a school-based clinic. These clinics typically have funding sources other than IHCP, and do not bill IHCP for the services they provide. For school-based clinics to bill for services provided to Hoosier Healthwise enrollees, the clinics must be IHCP-enrolled providers. Clinics that expect reimbursement from an MCO in the Hoosier Healthwise program must be IHCP-enrolled providers and must obtain MCO authorization prior to providing services. Services provided in a school-based clinic are usually limited to EPSDT, immunizations, or other primary care and preventive services.

School corporations can also provide IHCP-covered services to students as part of an individualized education plan (IEP). All claims for services provided to Hoosier Healthwise members in an IEP are carved out of the MCO capitation rate and adjudicated as fee-for-service claims by the fiscal agent. The provider must send these claims to the fiscal agent not to the MCO.

The OMPP strongly encourages MCOs to collaborate with school-based programs in the delivery of care to their members and to encourage their PMPs to assist in the coordination of medical services.

Pre-enrollment Provider Education

The MCOs can educate physicians interested in becoming PMPs about the Hoosier Healthwise program through face-to-face training sessions, brochures, and videos. The OMPP must approve prior to distribution all education and outreach materials designed for distribution to physicians interested in becoming PMPs.

Prior to enrolling PMPs in the MCO program, MCOs are encouraged to educate providers about the following:

- Hoosier Healthwise program goals
- Member PMP selection and PMP change process
- Practice requirements of a PMP, including the following:
  - Panel size limits
  - On-site availability requirements
  - 24-hour access standards
  - Provider disenrollment
  - Preventive health standards and requirements
  - Referral standards (for example, referrals for continuity of care)
- Quality improvement requirements (including EPSDT)
- Self-referral services
- Billing and reimbursement practices
- Covered and excluded services and referral practices
- Other relevant MCO-specific information

> *Note: All prospective PMPs must first be enrolled in the IHCP at the service location at which they want to be enrolled as PMPs. MCOs must verify IHCP enrollment with prospective PMPs prior to submitting PMP enrollment documents to EDS. If the prospective PMP is not IHCP enrolled, the MCO must tell the physician to contact EDS for an enrollment application, or the physician (or physician's group) can download the appropriate application from the Web site at http://www.indianamedicaid.com/.*

Post-Enrollment Provider Education

As part of the enrollment process for network PMPs, the MCO must educate PMPs about the following:

- *How PMPs are notified about panels* – MCOs provide member enrollment roster information to their contracted network PMPs. The MCO can retrieve a complete list of enrolled members (Enrollment Roster 834) with PMP assignments from EDS. Enrollment rosters are described in *Section 7: Member Eligibility and Enrollment.*
- *Universally accepted standards of preventive and other care* – These standards are determined by the MCO. MCOs are strongly encouraged to employ the practice standards provided later in this section. The Hoosier Healthwise Program updates these practice standards as needed.
- *Medical records retention and availability* – This information is described in this section.
- *PMP authorization requirements* – This information is described in this section.
- *IHCP-covered but MCO-excluded services* – This information is described in *Section 4: Managed Care Services*.
- *Provider claims dispute* – These procedures are developed by the MCO. Minimum requirements are described later in this section.
- *Provider helpline* – MCOs must offer a telephone helpline to providers. The MCO must report provider helpline performance statistics as described in the *MCO Reporting Manual.* The MCO

helpline staff must be prepared to respond to provider concerns including, but not limited to the following:
  - Enrollment and disenrollment from the MCO
  - Provider grievances and claim disputes
  - Covered services
  - Self-referral services
  - Provider network development as described in *Section 8: MCO Enrollment and Network Development* section of this manual
  - Quality improvement requirements as described *Section 9: Quality Improvement Program* of this manual
  - Billing requirements
  - Eligibility issues
  - Preventive health standards and requirements (including EPSDT)
  - Shadow claim requirements as described *Section 10: Management Information Systems* of this manual

- *Reassignment of a member to another PMP* – This process, as initiated by the provider, is described in *Section 7: Member Eligibility and Enrollment.*

Panel Size

A PMP designates the desired panel size as part of the PMP enrollment process. The panel size is the number of Hoosier Healthwise members a PMP agrees to accept. The minimum and maximum allowable panel size designations are 150 and 2,000 Hoosier Healthwise members respectively. The OMPP grants exceptions for panel sizes less than 150 or greater than 2,000 on a case-by-case basis. A panel size change request form must be submitted to the OMPP for approval of panel sizes less than 150 and greater than 2,000. The OMPP considers written requests for panel size adjustments, taking into consideration multiple factors listed below. Documentation of pertinent factors *include,s but is not limited to,* the following:

- The PMP must be active with at least one year enrollment in the Hoosier Healthwise managed care program and close to the 2,000 panel size initial limit before submitting a request for a panel size increase to greater than 2,000 members
- Overall access in the geographic area (for instance, an underserved area or underserved specialty)
- Percent of total practice that consists of Hoosier Healthwise members
- Date of last panel size change, or PMP enrollment date, whichever is later
- Support staff and policies related to sharing patient management (for example, other physicians in group practice with the same specialty or the number of advanced practice nurses in group practice)
- Number and type of complaints filed for the PMP or group practice
- Review of any Surveillance and Utilization Review (SUR) investigations of the PMP or group practice
- PMP credentialing and utilization review profiling summary results information
- PMP after-hours arrangements
- Review of recommendations by the Managed Care Entity (MCE) medical director

Appendix I: MCO PMP Enrollment Sheet includes a checklist of panel size greater than 2,000 criteria.

PMPs who obtain approval to increase their panel size to greater than the maximum of 2,000 members must maintain acceptable quality and access standards such as the following: 24 hour availability,

appointment access times, quality and timely health care provision consistent with established community standards of care, minimal number of member complaints, and so forth. The maximum panel size cannot exceed 2,500 members. A PMP can request a panel size between 2,000 and 2,500 members. If a PMP reaches a panel of 2,500 members and requests a panel size higher than 2,500 members, this policy and process is reviewed again. Physicians treating children with special health care needs are subject to the same panel size requirements as other PMPs. The program maintains the requirement that only individual physicians, and not physician groups, enroll as PMPs.

The panel size includes only Hoosier Healthwise enrollees and does not include IHCP enrollees in other programs. The panel size is applicable to the PMP and not to the individual service locations at which a PMP may practice. The panel of a PMP enrolled with two Hoosier Healthwise service locations is a combination of the patients assigned to each location. For example, if a PMP is enrolled with a panel size of 500 and has two active service locations, the members assigned to the PMP are spread across the two locations.

The panel size applies to an individual PMP and may not be shared among a group of PMPs. Because Hoosier Healthwise members are assigned to a specific PMP and not to a group, a group practice cannot opt to share a panel of 600 members assigned to the group. A billing group of four PMPs could each enroll with a panel of 150 members and provide services to members assigned to other group members.

PMPs cannot exceed the designated panel size limit except in the following circumstances:

- A PMP with a full panel will receive auto-assignments of previously assigned Hoosier Healthwise members.
- A PMP with a full panel will receive auto-assignments of family members (identified by case number) of currently assigned members.
- PMPs may have the option to increase a full panel by up to five Hoosier Healthwise members once per calendar quarter if the member or family member has a previously established relationship with the PMP determined by criteria established by the enrollment broker.
- The OMPP reviews and approves other circumstances that could result in a panel size change.

Exceptions to Panel Size Limits for New PMPs

To provide appropriate access to health care in the Hoosier Healthwise program, it may be necessary to make exceptions to the panel size minimum or maximum requirements in specific geographical areas or for specific provider specialties.

The OMPP can approve the enrollment of a new PMP with a *panel size below the minimum* requirement on a case-by-case basis due to specific circumstances in an area. This exception applies to all PMPs with a specific specialty, such as OB/GYN, in an area where increased access to PMPs with a particular specialty is warranted. PMPs who have reached, or are near, the maximum panel size limit of 2,000 can request a *panel size above the maximum*. The OMPP considers this request on a case-by-case basis.

The MCO provider network personnel who identify a general need for adjusted panel sizes in service areas must request such adjustments in writing, with supporting justification to the OMPP.

Implementing Panel Size Adjustments

The following information details the steps for the initial enrollment of a PMP with a panel size outside the established Hoosier Healthwise program minimum or maximum sizes:

- The MCO requests a panel size adjustment in writing from the OMPP with supporting justification for the request.
- The OMPP makes a decision based on facts pertinent to the case.
- The OMPP sends written notification to the MCO and the fiscal agent that a specific provider in a specific area (county) can be enrolled with an adjusted panel size if requested.
- The OMPP Managed Care Unit staff authorizes the adjustment and forwards it to the provider enrollment specialist for entry in Indiana*AIM*.

Changes to Panel Sizes for Currently-Enrolled PMPs

Currently-enrolled **PMPs can increase their panel size** to the program maximum of 2,000 at any time by submitting a written request to the MCO. The Hoosier Healthwise program policy requires that increases in PMP panel sizes be made in increments of no less than 25 members. On receipt of a panel size increase request from a PMP, the MCO submits the *MCO Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent's provider enrollment specialist who updates the PMP's record in Indiana*AIM* to reflect the change. This form is located in *Appendix H: Hoosier Healthwise PMP Panel Size/Panel Hold Cover Form-Update*.

The minimum increment can be relaxed, allowing a PMP with a full panel to add up to five members per calendar quarter as follows:

- The enrollee has a previously-established relationship with the PMP as determined by the enrollment broker's established criteria.
- The enrollee's family member (identified by case number) selects the PMP.
- Both the member and the PMP are in agreement with the request.

The enrollment broker controls, monitors, and tracks requests to add to full panels. After the enrollment broker confirms that a request meets the criteria outlined, the broker coordinates the request with the fiscal agent's PMP enrollment coordinator. When the enrollment has been entered in Indiana*AIM*, the enrollment broker notifies the MCO of the addition to the PMP's panel.

PMPs can also request their panel size be lowered at any time by making a written request to the MCO. However, the panel size does not drop below the number of currently enrolled members assigned to the PMP's panel. When a PMP submits a request to lower its panel size, members are not removed from the PMP's panel. MCOs must understand this and communicate this to PMPs who request panel size decreases. On receipt of a panel size reduction request from a PMP, the MCO submits the *MCO Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent PMP enrollment coordinator who updates the PMP's record in Indiana*AIM* to reflect the change. This form is located in *Appendix H: Hoosier Healthwise Change Forms*.

Panel Hold Requests

A PMP can request that the panel size be temporarily placed on hold to prevent new assignments to the practice by selection or default auto-assignment. MCOs must educate their PMPs that a panel hold does not stop assignment of members with the same case ID or members who have had a previous relationship with the PMP (auto assignment's case ID and previous PMP logic). Panel hold requests are usually granted in situations expected to be temporary, and are not used as a means to circumvent the program's minimum panel size requirements or to manipulate a PMP's panel with regard to a specific member assignment. The reasons for a panel hold request are documented and monitored to

maintain the program's integrity for access reporting and to ensure adequate openings to accommodate new Hoosier Healthwise enrollees who self-select or are auto-assigned to a PMP within the program.

On receipt of a request to place a PMP's panel on hold, the MCO submits the *MCO Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent's PMP enrollment coordinator who updates the PMP's record in Indiana*AIM* to reflect the change.

Reasons for Granting a PMP Panel Hold Request

The following are examples of acceptable reasons for granting a PMP panel hold request:

- PMP has a personal situation expected to be of temporary duration such as maternity leave or short-term disability
- PMP is temporarily unable to accept new assignments for professional reasons such as moving practice location
- PMP is taking a temporary leave of absence from the practice
- MCO is researching contractual issues with the PMP, such as quality of care issues or other concerns identified by the program

Procedure for Implementing a PMP Panel Hold Request

An authorized representative from the MCO sends the *MCO Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent's PMP enrollment coordinator.

The following information is required:

- PMP signature acknowledging the panel hold request
- Reason for the panel hold request
- Expected duration for the panel hold
- Signed acknowledgement by the MCO representative that the request meets the program criteria for panel holds as described above
- OMPP approval for panel hold requests for reasons other than those outlined previously
- Date the MCO will review the panel hold request with the PMP for removal of the hold

The fiscal agent's PMP enrollment coordinator activates the panel hold in Indiana*AIM* and maintains documentation in the PMP file.

The MCO reviews the panel hold with the PMP within the agreed upon time frame and sends documentation to the fiscal agent's PMP enrollment coordinator to remove or extend the panel hold.

Temporary Removal of an Approved Panel Hold

PMPs with an approved panel hold can request to have the hold temporarily removed to have a family member of a current patient added to the PMP's panel. This is only necessary when a family member of the current patient has a different case ID number. Family members with the same case ID number are auto-assigned to the same PMP and do not require manual intervention. Implementation of this procedure is time-sensitive to prevent auto-assignments while the panel hold is temporarily removed and replaced. To prevent unintended assignments, the fiscal agent and the enrollment broker establish telephone contact prior to beginning the systematic update process. This contact is maintained until

the process is complete. Because this is a manual process that requires coordination between the fiscal agent and the enrollment broker, MCOs must be aware of the following processing requirements:

1. The MCO forwards member enrollment request to a PMP with a full panel to the enrollment broker for special processing.
2. The enrollment broker receives a member enrollment request with notification from a PMP that the member is being added to its panel.
3. The enrollment broker contacts the fiscal agent's provider enrollment supervisor or provider enrollment specialist.
4. The fiscal agent removes the panel hold and notifies the enrollment broker when the action is completed.
5. The enrollment broker enrolls the approved Hoosier Healthwise member to the PMP as requested and immediately notifies EDS when the enrollment is complete.
6. The fiscal agent replaces the PMP panel hold.

This process must be completed in one day to avoid the possibility of unintended assignments to the PMP during the time the panel hold was removed.

Exceptions to the Panel Hold Request

MCOs and PMPs must understand that the panel hold request prevents self-selection or auto-assignment of new members with the exception of new family members or prior panel members. PMPs with a panel hold continue to appear on provider lists from which potential Hoosier Healthwise members make a PMP selection. Except for members with a previous relationship with the PMP in the Hoosier Healthwise program or the family member (identified by a common case number) of a current panel member, new members are not assigned during the temporary panel hold period. Again, it is important for MCOs to communicate this to their PMPs.

PMP Open Network Changes

To make an open change from one network to the other, PMPs must send a signed, dated *Program Change Request Form* to the MCO for receipt by the EDS Managed Care no later than the first day of the last month of a calendar quarter. For example, a PMP wishing to change enrollment from MCO 1 to an MCO 2 network for the quarter beginning April 1 must send the PMP open network change request to the MCO 2. MCO 2 forwards this to EDS for receipt no later than March 1. Requests received after March 1 are processed for an effective date of July 1, the beginning of the next calendar quarter. This form is found in *Appendix H: Hoosier Healthwise Change Forms*. Open network change requests received after the deadline are processed for an effective date in the next calendar quarter.

Provider Enrollment

The MCO components of Hoosier Healthwise are subprograms of IHCP. As such, participating providers must be IHCP-enrolled. The MCO is responsible for ensuring that all of its providers are IHCP-enrolled at the service location where they wish to participate as a PMP. The MCO is also responsible for ensuring that there are sufficient providers to adequately serve the enrolled members.

Provider enrollment activities are governed by the following criteria:

- State-contracted provider outreach personnel assume responsibility for education of providers enrolled in the MCOs educate their network providers. State-contracted provider personnel from the enrollment broker or the fiscal agent can also provide general information about the Hoosier Healthwise program and all of its networks.
- Once enrolled in the IHCP, PMPs contract directly with the OMPP for the MCOs for their networks. PMPs are allowed to enroll in with an MCO although they may only be open for new member enrollment in one network at a time.
- PMPs are limited to a maximum total panel size of 2,000 Hoosier Healthwise members. This panel may be composed solely of members in an MCO. To provide adequate PMP availability to Hoosier Healthwise enrollees, the OMPP has established a minimum allowable panel size of 150 Hoosier Healthwise enrollees.
- Exceptions to the panel size maximum are only granted to allow the PMP to accept patients previously assigned to the PMP's panel in Hoosier Healthwise, family members of currently enrolled individuals, and in designated provider shortage areas as determined by the OMPP. Exceptions to the panel size minimum are also granted in areas where a reduced panel size is necessary to encourage provider participation. Details about these exceptions are outlined elsewhere in this section.
- PMPs can be enrolled in only one MCO per region.
- If a PMP disenrolls from Hoosier Healthwise or disenrolls as an IHCP provider entirely, MCOs must ensure that members continue to receive care until another PMP is chosen or assigned. Further information about PMP disenrollment is contained in this section.

Indiana Health Coverage Programs Provider Enrollment Processing

To participate as a PMP or specialist in the Hoosier Healthwise program, a provider must be enrolled as an IHCP provider. A provider is enrolled in the IHCP when all of the following conditions have been met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to State or federal law, or otherwise authorized by the IFSSA.
- The provider has completed, signed, and returned an IHCP Provider Agreement and any other forms required by the IHCP.
- The provider has been assigned an IHCP provider number.
- Physicians must be actively enrolled at the service location where they wish to practice as a PMP prior to enrolling as a PMP at that location.

There are two types of IHCP providers:

- Billing providers (sole proprietorship, group)
- Group members (rendering providers)
  - A *sole proprietorship* is a provider who owns a practice location where he or she is the sole practitioner performing services with an unshared tax ID number.
  - A *group* is a business entity that owns one or more service locations where providers are employed or contracted to perform professional services on behalf of the business entity.
  - A *group member* is a rendering provider who is employed or contracted to render services to IHCP members. Group members cannot have a billing service location in Indiana*AIM*. All services are billed using the group's IHCP ID number.

The IHCP provider enrollment procedures are designed to ensure timely, accurate, and efficient processing of provider enrollment applications. This procedural base is the focus of provider

participation and is critical for accurate claims processing. It is the MCO's responsibility to ensure that any network providers delivering services to members in the Hoosier Healthwise program are enrolled as IHCP providers. Providers complete the initial enrollment by completing the *Indiana Health Coverage Programs Provider Agreement* and submitting it by U.S. mail to:

EDS Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Detailed information about compling the provider enrollment application and agreement is found in the *IHCP Provider Manual* on the Web site at http://www.indianamedicaid.com/. Providers may download enrollment applications from this Web site. Providers may also contact Customer Assistance by telephone at 1-800-577-1278 or (317) 655-3240 to request enrollment applications and to obtain answers to questions about provider enrollment in the IHCP.

After completing IHCP enrollment, PMPs enroll with the OMPP through the MCO to participate in an MCO network.

MCO PMP Enrollments

MCOs submit PMP enrollments in their networks to the EDS PMP enrollment coordinator. The PMP enrollments are paper files mailed to EDS Managed Care.

The form for enrolling a PMP in the MCO network is similar and may be found in *Appendix H: Hoosier Healthwise Change Forms*. Additionally, the submission must contain the signature page from the provider's contract with the MCO acknowledging enrollment in the Hoosier Healthwise program. The date of the signature can be no earlier than the effective date of the MCO's *current* contract with the State.

MCOs submit enrollment forms to the EDS Managed Care Unit at the address provided previously in this section so that PMPs can be enrolled in the networks. The following procedure has been implemented to allow the EDS Managed Care to readily identify the submission as one belonging to an MCO, and to provide the MCO with a means of confirmation that the enrollments have been processed:

- The PMP enrollment requests must be sent with a cover letter containing the MCO's name, signature of the MCO provider representative, MCO fax number, and an itemized list of the enrollment forms submitted.
- The itemization must include fields for the following information:
  - PMP name
  - IHCP provider number
  - Effective date
- The PMP enrollment form must be attached to the signature page from the PMP's contract with the MCO. The date of the signature can be no earlier than the effective date of the MCO's current contract with the State.
- The MCO must complete the PMP name and provider number.
- The EDS PMP enrollment coordinator annotates the MCO cover letter to indicate the effective date or the reason the enrollment could not be processed.
- On receipt of the MCO's PMP enrollment forms, the EDS PMP enrollment coordinator enters the data into Indiana*AIM*, verifying the following information:
  - Valid IHCP numbers
  - IHCP eligibility
  - Valid PMP provider type and specialty

  - Valid IHCP service location
  - Valid group and individual relationships
  - Number of PMP service locations
  - Acceptable panel size

- The EDS PMP enrollment coordinator confirms the disposition of the enrollments by sending an e-mail confirmation to the submitter.

Because PMP enrollment to the MCO network is a manual process, no exception reports are generated.

Provider Disenrollment

A PMP can be disenrolled from the Hoosier Healthwise program for various reasons. The PMP disenrollment process was designed to provide continuing care for Hoosier Healthwise members whose PMPs leave the Hoosier Healthwise program and are no longer available to its members. A timing guide for this process is contained in *Appendix J: PMP Disenrollment Timeline*.

Overview of PMP Disenrollment Reasons

Disenrollment processes are designed to accommodate Hoosier Healthwise members when the PMP becomes unavailable due to immediate, unforeseen reasons such as death or loss of license. When a PMP disenrolls for a mandatory reason, the members assigned to that PMP are auto-assigned to another PMP to allow continuous access to health care in the Hoosier Healthwise program.

Other disenrollment processes are designed to allow an orderly transition of care for Hoosier Healthwise members assigned to a PMP who becomes unavailable due to retirement, a move to a different network, or other circumstances that can be planned. When a member is linked to a PMP who disenrolls for voluntary reasons, the member is notified of the pending disenrollment and encouraged to select another PMP prior to the date the current PMP becomes unavailable. The new assignment is processed as a PMP change and submitted to the enrollment broker for entry into Indiana*AIM*.

PMP disenrollments fall into two general categories:

- Disenrollment without re-enrollment occurs in circumstances where the PMP disenrolls (or is disenrolled) from his or her current Hoosier Healthwise network and is not available to members in a different Hoosier Healthwise network. Examples include the PMP's death, loss of license, retirement, relocation out of a Hoosier Healthwise service area, disenrollment from the Hoosier Healthwise program for any other reason, or IHCP provider enrollment termination. Members linked to a PMP that is disenrolled without re-enrollment are usually notified to self-select a new PMP and are linked through a manual assignment process with the enrollment broker.
- Disenrollment with re-enrollment allows an orderly transition of Hoosier Healthwise members assigned to a PMP from one Hoosier Healthwise network or service location to the same PMP in a different Hoosier Healthwise network or service location. When a PMP disenrolls and re-enrolls, members linked to that PMP are usually auto-assigned to the same PMP in a different network or service location.

Submitting the PMP Disenrollment Request

MCOs are responsible for submitting PMP disenrollments to EDS for processing in Indiana*AIM*. The disenrollment request includes the following information submitted on the transmittal forms in *Appendix H: Hoosier Healthwise Change Forms*:

- MCO name and region
- PMP name, individual and group provider numbers, and service locations (alpha code)
- Signed letter from the PMP or PMP's representative stating the intent to disenroll and the reason for the disenrollment (except in the case of the PMP's death) or if the PMP is unavailable to obtain signature, such as, if he or she moved and did not leave contact information. The signed letter from the PMP should contain a requested effective date. If the PMP declines to provide the disenrollment reason in writing, the MCO can provide it in a cover letter requesting the disenrollment.
- Signature of the authorized MCO representative
- Notification of whether disenrollment notification letters must be suppressed

The detailed PMP disenrollment processes indicates whether letters are automatically generated due to the disenrollment reason. There may be instances in which EDS determines that a letter to a Hoosier Healthwise member should be suppressed. For example, if a PMP disenrolls from one service location, but is available to Hoosier Healthwise members at a different location with the same address.

An MCO can decide to use the automated PMP disenrollment process for a circumstance that differs from the intention of the original design. Some instances can require immediate reassignment of the members to another PMP. For example, a PMP may fail to meet the network standards during recredentialing or other review process. If the MCO does not have sufficient time to notify the PMP's members of disenrollment, the MCO can submit a mandatory disenrollment request, causing the members to be auto-assigned to available PMPs in their network.

The OMPP permits MCOs to use mandatory or voluntary disenrollment reasons to fit their business needs as long as the Hoosier Healthwise program and its participants are not adversely affected. It is incumbent upon the MCOs to fully understand the PMP disenrollment process and to use it within the Hoosier Healthwise program's stated policies and philosophy of providing access, continuity, and quality care to its membership. The following pages provide detailed information about the PMP disenrollment reasons and the result of each. The designations mandatory and voluntary described here are to illustrate how the Managed Care Unit and Indiana*AIM* process PMP disenrollments. MCOs and the enrollment broker need only identify the disenrollment scenario. The EDS assigns the appropriate disenrollment reason code based on the scenario provided.

PMP Disenrollment without Re-enrollment from the MCO

A PMP can voluntarily disenroll from a Hoosier Healthwise MCO, or from the Hoosier Healthwise program entirely. Usually, a PMP disenrollment is considered voluntary only when the PMP is not available to members in another Hoosier Healthwise network. Examples of voluntary disenrollment reasons include the following:

- Provider is moving the practice out of the MCO service area
- Provider closes the practice due to retirement or other reason

In these situations, the PMP will give some prior notice to the MCO, allowing for a transition of the patient panel to another PMP within the MCO's network. After the MCO becomes aware of a PMP's intent to voluntarily disenroll from the MCO network or the Hoosier Healthwise program, the MCO does the following:

- Notifies EDS immediately in writing of the PMP's intent to voluntarily disenroll
- Facilitates member assignments to other PMPs within the network. The provider is not disenrolled until all members have been reassigned.

- Forwards member PMP changes to the enrollment broker for processing in Indiana*AIM*
- **Must provide** EDS with written notice specifying the projected end date by five working days prior to the 24th of the month prior to the month in which the disenrollment is effective. The disenrollment notice, submitted on the disenrollment request form, includes the following:
  - MCO name
  - PMP name
  - Provider individual and group ID numbers
  - Service locations
  - Signed letter from the PMP stating the intent to voluntarily disenroll, including the disenrollment reason and effective date
  - Signature of the authorized MCO representative.
  - While a signed letter from the PMP is required, except in the case of death, the MCO can provide the disenrollment reason in a cover letter with the disenrollment request if the PMP declines to specify the reasons for disenrollment in the signed letter.

MCOs can write a customized letter to the members of a disenrolling PMP to provide information about the PMP's departure from the network as well as information about the selection and transition to a new PMP. The OMPP must first approval all customized letters. On receipt of notification from the MCO of the PMP's intent to voluntarily disenroll, EDS does the following:

- Enters disenrollment pending on the Indiana*AIM* provider file. This begins the disenrollment process, prevents the PMP from receiving any new member assignments, and suppresses the provider's name from future PMP listings.
- Confirms that the disenrollment has been processed with the requestor
- Initiates the systematic entry of the PMP disenrollment date in Indiana*AIM*. The PMP is not disenrolled until all members have been reassigned.
- Generates confirmation letters to members who have chosen a new PMP as shown in *Appendix J: PMP Correspondence*
- Sends a PMP disenrollment confirmation letter to the PMP as shown in *Appendix J: PMP Correspondence*
- Sends the PMP disenrollment confirmation letter to the MCO as shown in *Appendix J: PMP Correspondence*

The disenrollment without re-enrollment of a PMP from an MCO network requires the MCO to facilitate the assignment of the PMP's patients to other network PMPs if the PMP is not otherwise available in the Hoosier Healthwise network. The PMP's disenrollment is not final until all members assigned to the PMP have been reassigned to other PMPs. The MCO is responsible for all members assigned to a disenrolling PMP until another PMP selection has been made.

PMP Panel Transfer Requests

Policy

It is the OMPP's policy to allow a Hoosier Healthwise PMP or the MCO to request the transfer of the PMP panel to another PMP in the event that the current PMP is unable or unwilling to continue providing service to those members assigned to him or her.

The OMPP approves these requests if the current PMP requests the panel transfer and the members are better served by establishing a new PMP at the same location or one within the MCO network. These requests are approved if the request comes from the MCO only if the PMP is not available to make the request on his or her own behalf (for example, due to the death or relocation).

These requests must be submitted to the enrollment broker for review and approval before the PMP changes are processed into Indiana*AIM*. The enrollment broker confirms that the PMP is no longer available to members at a new location or network. When the review is complete and approval granted, the enrollment broker notifies the requesting MCO and EDS that the request has been approved. EDS suppresses the member notification letters about the PMP disenrollment and the member receives the proper Indiana*AIM*-generated letter advising of the PMP change. If the request is not granted, the enrollment broker notifies the MCO of the denial and the reasons for it.

The MCO submits the PMP changes to the enrollment broker using the appropriate form and the proper change reason code.

All parties understand that the member may make another selection if they are not satisfied with the selection made by the current PMP or MCO.

Procedure

The following are the circumstances under which a panel transfer request can be requested and the procedures to be followed.

PMP Request

- The PMP signs a letter to request a panel transfer. This letter includes the reason why heor she is no longer willing or able to serve as a PMP. The letter should also name a specific PMP or PMPs who should receive assignment of the current PMP's members.

> *Note: The PMP must sign the letter. An office staff member should not sign because of the potential for a conflict of interest. For example, the PMP may be leaving a group practice and opening a solo practice. Both the PMP and the group may want to keep the members. However, because members are linked to a PMP and not a group, members should follow the PMP to the new location. In some cases, the PMP may choose to transfer his or her members because the new practice location is a considerable distance from the current location.*

- The MCO must send the enrollment broker the MCO's *PMP letter and a Panel Transfer Request Form* by no later than the 15th of the month for a disenrollment to be effective at the end of that month.
- The enrollment broker reviews the documentation and either approves or denies the request. The enrollment broker generally completes and approved or denies the request and communicates the decision within 48 hours. However, if it receives insufficient or questionable documentation, it may take longer to process the request because the enrollment broker must attempt to confirm the request and the fact that the PMP does wish for his or her panel to be transferred.
- When the request is approved, the enrollment broker sends an e-mail notification of the approval to the requesting MCO and EDS.
- When the request is denied, the enrollment broker sends an e-mail notification to the requesting MCO. This e-mail outlines the reasons for the denial.
- The enrollment broker submits a written notification of approval or denial to the MCO.
- This approval document ***must*** accompany the disenrollment paperwork the MCO sends EDS. This approval form confirms that EDS should suppress the member notification letters of the PMP's disenrollment.

- Upon receiving approval, the MCO should submit the PMP changes to the enrollment broker on the appropriate form with the appropriate change reason code for processing into Indiana*AIM*.
- Members receive system-generated letters informing them of their new PMP assignment.

Plan Request

- The MCO signs a letter to request a panel transfer. This letter should include the reason the PMP is no longer willing or able to serve as a PMP and why the PMP is not making the request. An appropriate reason could include death or serious illness or relocation with no forwarding address or forwarding number. The letter should also name a specific PMP or PMPs who should receive assignment of the current PMP's members. The MCO forwards the PMP letter and a *Panel Transfer Request Form* to the enrollment broker no later than the 15th of the month for a disenrollment to be effective at the end of that month.
- The enrollment broker reviews the documentation and either approves or denies the request. The enrollment broker generally completes and approved or denies the request and communicates the decision within 48 hours. However, if the enrollment broker receives insufficient or questionable documentation, it may take longer to process the request because the enrollment broker must attempt to confirm the request and the fact that the PMP does wish his or her panel to be transferred.
- When the request is approved, the enrollment broker sends an e-mail notification of the approval to the requesting MCO and EDS.
- When the request is denied, the enrollment broker sends an e-mail notification to the requesting MCO. This e-mail outlines the reasons for the denial.
- The enrollment broker submits a written notification of approval or denial to the MCO. This approval document ***must*** accompany the disenrollment paperwork that the MCO sends to EDS. This approval form confirms that EDS should suppress the member notification letters of the PMP's disenrollment.
- Upon receiving approval, the MCO should submit the PMP changes to the enrollment broker on the appropriate form with the appropriate change reason code for processing into Indiana*AIM*.
- Members receive system-generated letters informing them of the new PMP assignment.

PMP Disenrollment with Re-enrollment from the MCO

Disenrollment with re-enrollment of a PMP from the Hoosier Healthwise program may be required. This precludes the provider from continuing patient care during the period after the member is notified and before the member selects another PMP. Additionally, PMP disenrollments with re-enrollment are processed as mandatory if the disenrolling PMP is available to members in a different Hoosier Healthwise network. Some reasons for a mandatory PMP disenrollment include:

- PMP's individual or group IHCP eligibility is terminated due to death, loss of license, or disability
- PMP's specialty changes to a non-managed care specialty
- PMP's enrollment within a group is terminated
- PMP's service location is no longer active

> *Note: Additional information about PMP disenrollment with re-enrollment in a different network is found at the end of this section.*

- PMP disenrolls from a group location to open an individual practice location or disenrolls from an individual practice location to join a group

- PMP disenrolls from one group and enrolls with another group

The MCO initiates the disenrollment process for voluntary PMP disenrollments as described previously. Physicians requiring mandatory disenrollment for one of the reasons listed are identified either by Indiana*AIM* (loss of license) or by the MCO (letter from PMP stating intent to disenroll from the MCO network). MCOs submit the request for mandatory PMP disenrollments to the fiscal agent (EDS) using the appropriate *MCO Network Disenrollment Request Form* provided in *Appendix H: Hoosier Healthwise Change Forms*.

MCO PMPs are disenrolled with the usual end-of-the month end-date. EDS Managed Care enters a mandatory disenrollment and sends an e-mail to the appropriate MCO stating that at the end of the month, the provider will be disenrolled as a PMP for the reason requested, such as, death.

Immediately on notification of a mandatory disenrollment, EDS does the following:

- Verifies the disenrollment reason and, if appropriate, enters a disenrollment pending status in the provider file in Indiana*AIM* to suppress the PMP's name from PMP listings and prevent further member assignments
- Approves the disenrollment effective the last day of the month if notice is received at least five working days before the 24th of the month. Disenrollments approved after the 24th of a month are effective the last day of the following month with the MCO maintaining responsibility for the PMP's panel until all members are reassigned
- Notifies members with a letter provided in *Appendix M: PMP Correspondence* that the PMP is no longer participating in Hoosier Healthwise. This letter also instructs members to call the MCO member services hotline to select another PMP.
- Sends a letter to the MCO stating the PMP disenrollment, reason, and effective date
- Notifies the PMP of the disenrollment effective date and reason
- Auto-assigns members to a new PMP within the MCO's network (if possible) who have not been reassigned by the 25th day of the month in which the disenrollment occurs if the disenrolled PMP is not available to members in the Hoosier Healthwise program
- Auto-assigns members to the same PMP at the new service location, or new network, if applicable
- Generates PMP confirmation letters to members who have been auto-assigned or have made a PMP change

For a mandatory PMP disenrollment from the Hoosier Healthwise program, the MCO continues to provide care to assigned members until members have selected another PMP or have been auto-assigned.

IHCP Disenrollment and PMP Disenrollment

If EDS Provider Enrollment receives an IHCP disenrollment request from an individual provider (a billing provider or dual provider) or from a group requesting disenrollment for one of its members (a service provider), and the provider is a PMP, Provider Enrollment does not process the disenrollment until the PMP disenrolls from managed care.

IHCP PMP disenrollments without re-enrollment for a voluntary reason are placed in a pending status for 30 days to allow the Hoosier Healthwise network organization efficient time to submit the necessary documents to EDS Managed Care. After 30 days, the PMP disenrollment are finalized in Indiana*AIM*, with or without the necessary documents from the Hoosier Healthwise network organization. The EDS PMP coordinator forwards an e-mail confirmation of the disenrollment to the affiliated Hoosier Healthwise network organization.

IHCP PMP disenrollments with re-enrollment for a voluntary reason are placed in a pending status for 30 days to allow the Hoosier Healthwise network organization to obtain the necessary documentation required and submit it to the EDS Managed Care Unit for processing.

IHCP PMP disenrollments with re-enrollments for an involuntary reason result in immediate PMP disenrollment without the necessary documents from the Hoosier Healthwise network organization. The EDS Managed Care PMP coordinator forwards an e-mail to the MCO explaining the reason for the PMP disenrollment.

Maintenance of Medical Records

The MCO must ensure that its participating providers maintain medical and other records of all medical services provided to enrollees by the MCO and its providers for seven years, in accordance with *IC 16-39-7-1*. The MCO medical records standards must be consistent to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Provider identification
- Allergies
- Past medical history
- Immunizations
- Medical information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for a living will or durable power of attorney for health care when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies
- EPSDT services

Providers must maintain medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Health records must be legible,

signed, dated, and maintained for at least seven years as required by *IC 16-39-7-1*. Confidentiality of personal health information (PHI) must be maintained in accordance with HIPAA.

The State (or its contractor) must have access to medical records for medical record reviews. In accordance with *405 IAC 1-5-1*, the PMP must retain all records relating to the provision of MCO services for at least seven years from the date of record creation. The PMP must transfer, at the request of the OMPP or the MCO, a summary or copy of the member's medical records to another PMP if the member is reassigned.

Any physician receiving payments from the IHCP for rendered services may not charge an IHCP member for medical record copying or transfer. Federal regulation *42C.F.R.447.15* states that providers participating in Medicaid must accept the State's reimbursement as payment in full (except that providers may charge for deductibles, co-insurance, and co-payments).

MCO Communications with Providers

The MCO must establish policies and procedures to maintain frequent communications and provide information to its provider network. As required by *42 CFR 438.207(c)*, the MCO must notify the State of significant changes that may affect a procedure at least 30 calendar days prior to notifying its provider network of the changes. The MCO must give providers 45 calendar days advance notice (per *IC 12-15-13-6*) of significant changes that may affect the providers' procedures (for example, changes in subcontractors). The MCO must post a notice of the changes on its Web site to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with *42 CFR 438.102*, the MCO must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. The MCO must develop and maintain a user-friendly Web site for network and out-of-network providers within six months of the effective date of the MCO's contract with the State. The OMPP must preapprove the MCO's Web site information and graphic presentations. The MCO may choose to develop a separate provider Web site or incorporate it into the home page of the member Web site. The provider Web site may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- MCO's contact information
- *MCO Provider Manual* and forms
- MCO bulletins or newsletters issued not fewer than four times a year that provide updates related to provider services, and updated policies and procedures specific to the Hoosier Healthwise population
- MCO's preferred drug list
- Claim submission information such as, but not limited to, MCO submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions
- Provider claims dispute resolution procedures for contracted and out of network providers
- Prior authorization procedures
- PMP and specialty network listings
- Links to the State's Web site for general IHCP or Hoosier Healthwise information
- Information about the MCO's chronic disease management program
- HIPAA privacy policy and procedures

The MCO must maintain a toll-free telephone helpline for all providers with questions, concerns, or complaints. The MCO must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a ten-hour business day, Monday through Friday. The MCO must maintain a system for tracking and reporting the number and type of providers' calls and inquiries. The MCO must monitor its provider helpline and report its telephone service performance to the OMPP as described in the *MCO Reporting Manual.*

The fiscal agent sponsors quarterly workshops throughout the state and an annual seminar for all IHCP providers. The MCO must participate in the quarterly regional workshops that are held in its service areas and the annual provider seminars.

An appropriate representative must be available to make formal presentations and respond to questions during the scheduled time(s). The OMPP also encourages MCOs to set up an information booth with a representative available during the annual seminar.

Provider Dispute Procedures

The MCO must promptly respond to provider complaints and appeals. The MCO must clearly document and maintain policies and procedures for registering and responding to complaints. The MCO must clearly communicate this information to all providers enrolled in the MCO. These policies and procedures must describe in detail the mechanism the MCO uses to track and respond to provider complaints and grievances, and provide a detailed description of specific positions responsible for performing each task. These processes must include specific timeframes and resources, including but not limited to electronic or manual reports, logs, and any other documentation used to track grievances and complaints. The MCO must also provide the OMPP with a detailed description of its written policies and procedures for handling provider grievances. The policies and procedures must follow the requirements set forth in the Indiana Administrative Code (IAC) at *405 IAC 1-1.6*.

In its quarterly report to the OMPP, the MCO must provide the number of provider grievances by type and number, both resolved and unresolved. Provider grievances must be recorded according to the framework established by the OMPP.

The content of denial notices to providers must include an explanation of specific criteria supporting a decision. If payment for a service is denied, the notice must cite not only the applicable rule provision, but also an explanation of how it fits the particular provision. For example, denials for non-emergency services must restate the definition of emergency services, and explain how the specific case fails to meet the criteria.

Practice Standards

Universally Accepted Practice Standards

There must be evidence that the MCO will further enhance quality of service to their Hoosier Healthwise members by requiring PMPs to adhere to nationally-accepted standards or guidelines for preventive care for pregnant women, infants, children, adolescents, and adults.

The MCO must use or develop preventive health guidelines based on reasonable medical evidence and national guidelines. Guidelines adopted by the MCO must include those endorsed by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American Society of Internal Medicine (ASIM), the American College of Physicians (ACP), the American College of Obstetrics and Gynecology (ACOG), the U.S. Preventive Services Task Force, the

American College of Surgeons, the National Cancer Institute (NCI), and the American Cancer Society. The MCO must provide evidence that it reviews the guidelines and scientific literature to be incorporated into the MCO preventive health guidelines. Guidelines must be shared with the MCO's QIC and subcommittees, if any, and must include provider participation. The QIC and subcommittees must have an opportunity to review, comment, and make modifications reasonable for local practices.

The guidelines must include the full spectrum of the Hoosier Healthwise population enrolled in the MCO. Primary and secondary prevention must be addressed for populations identified as being high risk. Practice guidelines must include areas of study, methodology, indicators, analysis, plans for corrective action, follow-up, and assessment of effectiveness.

The MCO must provide evidence that supports how it shares preventive health guidelines with MCO providers, including new and existing providers. There must also be evidence that the MCO has plans for sharing new guidelines and revisions to guidelines. Communications can include provider newsletters, mailings, and provider manuals.

The MCO must establish mechanisms to monitor and review provider compliance and consistency in following preventive care guidelines. Barriers must be identified.

MCOs must publicize to members the availability of preventive health services, guidelines for these services, and the recommended frequency or conditions under which prevention activities are required. MCOs may inform members through member newsletters, member orientation packets, member handbooks, and targeted mailings.

> *Note: Additional evidence-based clinical practice guideline information is available at the National Clinical Guidelines Web site at http://www.guidelines.gov/.*

Early and Periodic Screening, Diagnosis, and Treatment Program

The federally-established EPSDT program, known as HealthWatch in Indiana, is part of the IHCP and was established in 1967. The HealthWatch program is a children's preventive health care program providing initial and periodic examinations and medically necessary follow-up care. The program objectives are to improve the overall health of infants, children, and adolescents through early detection and treatment of medical conditions. These efforts can reduce the risk of more costly treatment or hospitalization that can occur when detection of a medical problem is delayed.

This program is available to eligible children from birth through 20 years old on a voluntary basis. Any medical provider enrolled in the IHCP is eligible to offer HealthWatch screenings for IHCP-enrolled infants, children, and adolescents. Medical providers can offer EPSDT services to new and existing IHCP patients. If the provider participates in the Hoosier Healthwise managed care program as a PMP, the provider **must** participate in HealthWatch and offer or arrange for the full range of EPSDT screenings, recommended immunizations, and follow-up care for members in the applicable age ranges.

To meet standards for preventive child health care, the State requires adherence to guidelines developed by the American Academy of Pediatrics (AAP). The AAP publishes a schedule of recommendations for screening components, frequency for screenings, and immunizations started in infancy. There is also an accelerated screening and immunization schedule for children older than two years old who have not already received the recommended screenings or immunizations. For additional information, refer to the HealthWatch Recommended Screening Techniques and Referral Standards in the *IHCP Provider Manual* and the *HealthWatch/EPSDT Provider Manual.*

MCOs are responsible for ensuring that members receive EPSDT services. *Section 10: Management Information Systems* provides more information. The OMPP conducts ongoing studies

for this designated focus area to measure results and monitor MCO compliance with this area of critical importance to Hoosier Healthwise program members. MCOs are required to report EPSDT compliance through submission of shadow claims as described in *Section 10: Management Information Systems*.

Prenatal and Pregnancy-Related Care

The OMPP has implemented pregnancy-related standards of care that are applied to members in all of the IHCP. MCOs must consider these as minimum standards for their Hoosier Healthwise enrollees. These standards of care are based on the American College of Obstetricians and Gynecologists (ACOG)-recommended policies that include prenatal, delivery, and postpartum care. In general, the IHCP provides coverage for 14 prenatal and two postpartum care visits, which ideally occur throughout a low-risk pregnancy as follows:

- First trimester – three visits
- Second trimester – three visits
- Third trimester – eight visits
- Postpartum – two visits within eight weeks of delivery

The program does not place limits on the number of prenatal visits reimbursed for a member identified with a complicating condition that causes her to be a medically high-risk patient. The IHCP reimburses for appropriate laboratory tests and screenings during the pregnancy and two postpartum visits.

These standards, including diagnoses designated as high-risk and recommended laboratory tests and screenings, are described in detail in the *IHCP Provider Manual*.

Members who enroll with an MCO, either voluntarily or by auto-assignment, in the third trimester of pregnancy must be given particular attention about continuity of prenatal care. MCOs must make a financial arrangement with an out-of-network provider to continue care through the pregnancy if the member does not wish to change doctors in the late stages of a pregnancy. *Section 4: Managed Care Services* lists MCO requirements for continuity of prenatal care.

Future Standards

MCOs are expected to add detailed practice standards for other patient conditions including the following:

- Breast cancer and mammography
- Cervical cancer and pap smears
- HIV/AIDS
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases
- Cholesterol screening
- Prevention of influenza
- Smoking prevention and cessation

- Immunizations
- Domestic violence

These standards are developed by the OMPP's Quality Improvement Committee (QIC) based on consultation with and recommendations from the following:

- IHCP physician providers
- Indiana medical community at large
- External Quality Review Organization (EQRO) as well as the Health Plan Employer Data and Information Set (HEDIS)
- Federal Agency of Health Care Policy and Research (AHCPR)
- Centers for Disease Control and Prevention (CDC)
- IHCP Coordinated Care Technical Assistance Group (TAG)
- Other Department of Health and Human Services (DHHS) collaborative TAG committees.

A medical director and one other person knowledgeable about managed care, quality improvement, and data analysis processes represents MCOs on the QIC committee. MCOs must have practice standards in place for any of the previously listed or other conditions must make these standards available to Hoosier Healthwise enrollees after review and approval by the OMPP.

Billing and Reimbursement Policies and Procedures

The MCOs adnd providers in their networks negotiate billing and reimbursement arrangements. These arrangements must support the MCO's general shadow claim, utilization, and other reporting requirements described in *Section 10: Management Information Systems*.

The MCO must pay providers for covered medically necessary services rendered to the MCO's members in accordance with the standards set forth in *IC 12-15-13-1.6* and *IC 12-15-13-1.7*, unless the MCO and provider agree to an alternate payment schedule and method. The MCO must pay or deny electronically-filed clean claims within 21 calendar days of receipt and clean paper claims within 30 calendar days of receipt. If the MCO fails to pay or deny a clean claim within these timeframes, but subsequently pays the claim, the MCO must also pay the provider interest as required under *IC 12-15-13-1.7(d).* A definition of a *clean claim* is set forth in *IC 12-15-13-0.6*. These standards apply to out-of-network claims for which the MCO is responsible and any other claims submitted by providers that have not agreed to alternate payment arrangements.

While the MCO may choose to subcontract claims processing functions, or portions of those functions, with a State-approved subcontractor, the MCO must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral, and will not result in confusion in the provider community about where to submit claims for payments. For example, the MCO may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, the MCO must ensure that the subcontracting organizations forwards claims to the appropriate processing entity. Use of a method such as this shall not lengthen the timeliness standards discussed in this section. In this example, the definition of *date of receipt* is the date of claim's receipt at the post office box.

Interest payments to Non-contracted Providers

Effective January 1, 1997, MCOs are financially responsible for interest payments on clean claims billed by non-contracted providers. The requirement ensures timely payment of claims for services

provided to Hoosier Healthwise enrollees. Interest is payable in accordance with provisions set forth in *IC 12-15-13*. Claims for services rendered by providers contracted with the MCO are not subject to this provision.

Billing and Balance Billing IHCP Enrollees

The IHCP and federal regulations specifically prohibit providers from charging IHCP enrollees for covered services except in specific, limited circumstances. IHCP-enrolled providers are required to accept the IHCP's determination of payment for covered services as payment in full, except for co-payments and any other patient liability payment as authorized by law. The provider maintains documentation that the member voluntarily chose to receive the service, knowing that it is not covered by the program.

The *IHCP Provider Manual* contains detailed information about billing IHCP members. Generally, IHCP-enrolled providers can bill members only under the following conditions:

- The service is not covered under the IHCP (for example, cosmetic procedures)
- The member has exceeded the program limitation for a particular service
- The member understands that IHCP does not cover the service and accepts financial responsibility prior to receiving a service that is not covered by the program
- The services provided are covered or non-covered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or non-covered
- An IHCP provider can bill an enrollee when the provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim filing limitation.

MCO contracted providers, as IHCP-enrolled, are subject to the same stringent policy outlined above. While the OMPP and Centers for Medicare and Medicaid Services (CMS) recognize that there may be circumstances unique to the managed care environment in which billing a member may be appropriate, the OMPP discourages this practice. If an MCO elects to permit its contracted providers to bill members under any circumstance, the MCO must do all of the following:

- Develop sufficient safeguards to ensure that members are able to access medically necessary services
- Ensure that members are not subject to any coercive practices
- Ensure that members are informed of their right to file a grievance

The MCO can permit a provider to bill a member for services that require authorization, but for which authorization is denied, if certain safeguards are in place and followed by the provider. MCOs must establish, communicate, and monitor compliance with procedures that must include at least the following:

1. The provider must establish that authorization has been requested and denied prior to rendering the service.
2. The provider can request MCO review of the authorization decision. The MCO must inform providers of the contact person, the means for contact, the information required to complete the review, and procedures for *immediate* review if necessary.

3. If the MCO maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied. Covered services may be available without cost in the MCO network if authorization is provided.
4. The member must be informed of the right to contact the MCO to file a grievance if the member disagrees with the decision to deny authorization.
5. The providers must inform the members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.
6. If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
   - The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
   - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
   - Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
   - The waiver must specify the date the services are provided and the services that fall under the waiver's application.
7. The provider must have the right to appeal any denial of payment by the MCO for denial of authorization.

Disclosure of Physician Incentive Plan

The MCO may implement a physician incentive plan (PIP) only if:

- The MCO makes no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and
- The MCO meets requirements for stop-loss protection, member survey, and disclosure requirements under 4*2 CFR 438.6*.

Federal regulations *42 CFR 438.6, 42 CFR 422.208*, and 42 *CFR 422.210* provide information about physician incentive plans, and the CMS provides guidance on its Web site. The MCO must comply with all federal regulations regarding PIP and supply to the OMPP information on its PIP as required in the regulations and with sufficient detail to permit the State to determine whether the incentive plan complies with the federal requirements. The MCO must provide information about its PIP, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Section 7: Member Eligibility and Enrollment

General Eligibility Information

Caseworkers in the local county office of Family Resources in the member's county of residence are responsible for Indiana Health Coverage Programs (IHCP) eligibility determination. County caseworkers are also responsible for updating member eligibility and personal data (such as changes in household, including births, deaths, and so forth) for continuing enrollees at periodic eligibility redeterminations. The county caseworker enters this data into the Indiana Client Eligibility System (ICES). Potential Hoosier Healthwise managed care members can also enroll at various enrollment centers located in hospitals, clinics, schools, and other outreach locations throughout the state. Enrollment center personnel help potential members complete applications and forward them to the local county office of Family Resources for processing.

EDS, as the Office of Medicaid Policy and Planning's (OMPP) fiscal agent, receives ICES enrollee eligibility updates that interface daily with Indiana*AIM*. Enrollee data retained in Indiana*AIM* is used to confirm eligibility for various IHCP programs, including Hoosier Healthwise, during claims processing. Providers may view enrollee eligibility data through Indiana*AIM*. County caseworkers enter changes to this data and Indiana*AIM* is updated by receipt of the daily ICES tapes. A member does not appear as *eligible* for the IHCP in Indiana*AIM* until EDS receives the member's ICES record.

The enrollment broker enrolls potential enrollees members in Hoosier Healthwise managed care by establishing a link between the enrollee and their selected Hoosier Healthwise primary medical provider (PMP) in Indiana*AIM*. The State retains sole responsibility for the maintenance of general IHCP eligibility and assignment of the member's aid category.

The OMPP is responsible for identifying potential enrollees eligible for enrollment in managed care based on broad aid categories established by ICES. The aid category also determines the benefit package to which the enrollee is entitled. Enrollment in Hoosier Healthwise managed care is mandatory for the majority of IHCP enrollees. The following groups of Hoosier Healthwise enrollees are eligible for one of the three benefit packages:

- *Package A (Standard plan)* – This package covers children, low-income families, and some pregnant women with a full range of IHCP benefits.
- *Package B (Pregnancy coverage)* – This package covers pregnant women with incomes up to 150 percent of Federal Poverty Level (FPL) for pregnancy-related and postpartum care, urgent care, family planning, pharmacy, and transportation services
- *Package C (Children's health plan)* – This package covers children younger than 19 years old in families with incomes greater than 150, but less than 200 percent of the Federal Poverty Level (FPL) for emergency, preventive, primary, and acute care services.

Enrollment in a managed care plan is **mandatory** for Hoosier Healthwise members in these broadly defined categories:

- *Temporary Assistance for Needy Families* (TANF) includes caretakers and children younger than 18 years old who meet eligibility requirements.
- *Pregnancy Medicaid* includes pregnant women who do not receive TANF. The full scope of benefits is available to women who meet strict income and resource criteria. Pregnancy-related coverage is provided to women whose income is below 150 percent of the FPL without regard to resources.

- *Children's Medicaid* includes children whose families do not receive TANF, but who are younger than 21 years old and meet the eligibility requirements.
- *Children's Health Insurance Program (Phase I expansion)* effective July 1, 1998, this program includes children from one to 19 years old in families with income up to 150 percent of the FPL who are uninsured and otherwise ineligible for IHCP benefits.
- *Children's Health Insurance Program (Phase 2 expansion – Package C)* – Effective January 1, 2000, this program covers children from birth through 19 years old in families with income greater than 150, but less than 200 percent of the FPL who are uninsured and otherwise ineligible for IHCP benefits. Unlike other categories of eligibility in Hoosier Healthwise, continued eligibility in Package C depends on payment of monthly premiums.

While participating in Hoosier Healthwise is mandatory for most members in the defined IHCP aid categories, members who are enrolled in aid categories *MA3* and *MA4* or otherwise designated as *foster children* or *wards of the court* **can** enroll in Hoosier Healthwise voluntarily. Guardians who choose a PMP for a ward of the court or foster child must call the Hoosier Healthwise Helpline directly. The help line representative verifies that the member's foster parent or guardian has received the appropriate education about the program prior to processing the entry in Indiana*AIM*.

Participation in managed care is **voluntary** for members in the following categories:

- Wards of the state
- Foster children

The State monitors the MCO's member enrollment by county and may limit the MCO's member enrollment in a particular county (or counties). Any member enrollment limitations that the State applies to the MCO are in the interest of protecting the mandatory status of the county by ensuring adequate member choice of health plans in accordance with *42 CFR 438.52*, and cannot limit or impede a member's choice in PMP selection.

The State requires the MCO to accept as enrolled all individuals appearing on the enrollment rosters or enrollees for whom the MCO receives capitation payment. The MCO and rendering provider are responsible for verifying the member's eligibility. If an MCO receives either enrollment information or capitation for a member, the MCO is financially responsible for the member. Hoosier Healthwise members selecting a PMP contracted with the MCO becomes enrolled members with the same MCO until that PMP no longer contracts with the MCO or the member changes his or her PMP. In accordance with *42 CFR 438.56, Sections (c), (d) and (e),* the MCO must have policies and procedures that allow members to change their PMPs.

IHCP Enrollees Not Eligible for Hoosier Healthwise

There are some subcategories of IHCP enrollees not eligible for the Hoosier Healthwise managed care program even though the enrollees are in an otherwise eligible aid category. Some examples of these groups are the following:

- Hoosier Healthwise members who move out of Indiana, even though they may retain IHCP eligibility while residing outside the state
- Illegal aliens who are eligible for limited benefits in the IHCP (Package E)
- Eligible for Medicare
- Members who receive long term care or level of care
- Members who receive IHCP hospice care

- Members who receive services under the Home and Community Based Services Waiver (HCBS) program
- Other members and potential members as determined by the OMPP

Hoosier Healthwise members in these sub-groups are disenrolled from the managed care program when they are identified. *Member Disenrollment* later in this section provides additional information.

The State has sole authority to determine if families or individuals meet the eligibility criteria and are eligible to enroll in the Hoosier Healthwise program.

Hoosier Health Identification Cards

Each newly-enrolled member in any IHCP benefit package receives a Hoosier Health identification card. This card identifies IHCP enrollees and provides current benefit information to their providers. New enrollees are assigned a recipient identification number (RID) on initial entry in ICES. The RID, unique to each enrollee, is a randomly generated, sequential identification number assigned for lifetime. The fiscal agent, EDS, produces and mails identification cards to new enrollees within three days of eligibility determination after the information transfers from ICES to Indiana*AIM*. Eligibility information on the plastic ID card is contained in a magnetic strip and is updated as necessary to reflect changes in eligibility status. The identification card is meant to be a permanent card, and is not reissued for enrollees who become again eligible after a period of ineligibility, unless the card has been lost or stolen. Enrollees who require replacement Hoosier Health Cards must contact their assigned caseworker in the local county office of Family Resources or call the Hoosier Healthwise Helpline at 1-800-889-9949.

The front of the Hoosier Health Card, shown in Figure 7.1, contains the following information:

- Enrollee's name and gender
- A 12-digit member identification (RID) number identifying the enrollee
- Birth date

Figure 7.1 – Hoosier Health Card

The enrollee, or the enrollee's parent or guardian, if the enrollee is a child, must sign the identification card.

Even when an enrollee presents a Hoosier Health Card, the provider is responsible for verifying eligibility prior to rendering services. Additional information about eligibility verification can be found later in this section. The *IHCP Provider Manual* provides detailed information about the Hoosier Health Card. Possession of a Hoosier Health Card does not guarantee current eligibility. Providers must verify eligibility each time they see an IHCP member, prior to rendering services.

Occasionally, ICES or an MCO identifies an enrollee who has been issued more than one RID in error. MCO personnel who identify a member with a duplicate RID must contact the EDS Managed Care with the information.

MCOs may present and distribute their own network ID cards for Hoosier Healthwise members enrolled in their networks. However, MCOs may **not** require Hoosier Healthwise members to produce a network card to receive services within the network.

Retroactive Eligibility

Traditional Medicaid allows retroactive eligibility in some circumstances as determined by the Division of Family Resources caseworker. Indiana*AIM* receives retroactive eligibility dates along with daily eligibility information. MCOs are not responsible for reimbursement for services provided to enrollees during a period of retroactive eligibility, except in the case of newborns whose mothers were enrolled in the MCO network at the time of birth. After enrollment in the IHCP, the newborn is automatically enrolled in the mother's MCO, retroactive to the date of birth. A delay of several days to a few months may occur from the birth of a newborn to the creation of a record in ICES that passes to Indiana*AIM*.

Hoosier Healthwise Enrollment

After the IHCP eligibility has been determined or redetermined, members in eligible aid categories must enroll in Hoosier Healthwise. Potential Hoosier Healthwise members receive program information and education from a benefits advocate (BA) employed by the enrollment broker located in the Division of Family Resources, in another authorized site, or an enrollment center. In addition to the BA, a potential member can seek enrollment assistance or program information from the Hoosier Healthwise Helpline at 1-800-889-9949.

The Hoosier Healthwise Helpline representative asks the caller to confirm that the education process has been completed prior to entering the PMP selection in Indiana*AIM*. If the potential enrollee has not received education about the Hoosier Healthwise program, the representative provides the necessary education or refers the potential enrollee to the BA before taking the PMP information.

Hoosier Healthwise-eligible enrollees are given 30 days from initial eligibility to complete the education process and make a voluntary PMP selection. Eligible members whose PMP selection is not entered into Indiana*AIM* within the first 30 days of eligibility are enrolled by the system's auto-assignment process described later in this section. During this 30-day enrollment period, Hoosier Healthwise enrollees can access medical care in the IHCP fee-for-service program. The exception to the 30-day fee-for-service period is for newborn children whose mothers were enrolled in an MCO network on the date of delivery. Additional information about newborn enrollment is included in this section.

Enrollment becomes effective when a potential enrollee is linked to a PMP in Indiana*AIM*. Enrollments entered in Indiana*AIM* between the 11th and 25th days of the month are effective on the first day of the following month. Enrollments entered between the 26th day of a month and the 10th day of the following month are effective on the 15th day of the following month. The member is enrolled the MCO health plan in which the selected PMP is currently open enrolled. The enrollee's PMP selection is verified by the *Hoosier Healthwise Welcome Letter* that contains the PMP name, address, phone number, and MCO network, name, and phone number.

A pregnant woman can select a PMP for her unborn child. The procedure for preselection of a PMP to care for the newborn child from the date of birth is included later in this section.

Members with Special Health Care Needs

The MCO must have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists. The Hoosier Healthwise managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

"Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

In accordance with *42 CFR 438.208(c)*, the State's enrollment broker conducts a Health Needs screening to identify members with potential special health care needs. The screening tool assigns children to one of the Living With Illness Measures (LWIM) screener health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need in one of seven different health domains:

- Functional limitations only
- Dependency on devices only
- Service use or need only
- Functional limitations and a dependency on devices
- Functional limitations and a service use or need
- Dependency on devices and a service use or need
- Functional limitations, a dependency on devices and a service use or need

The MCO receives the screening results for subsequent assessment by an MCO health care professional and facilitates care coordination. However, not all Hoosier Healthwise enrollees complete the screening tool and individuals can complete the screening tool with or without the assistance of the enrollment broker. The State requires the MCO to conduct a health needs screening for its members who have not received the screening at the time of enrollment.

In accordance with *42 CFR 438.208(c)(2)*, the MCO must have a health care professional assess the member when the health needs screening identifies the member as potentially having a special health care need. When the assessment confirms the special health care need, the MCO must coordinate the member's health care services with the member's PMP's plan of care. The MCO must offer continued coordinated care services to any special health care needs members transferring into the MCO's membership from another plan. For example, MCO activities supporting special health care needs populations must include, but are not limited to:

- Conducting the initial health needs screening to identify members who may have special needs
- Scoring the screening tool results
- Distributing findings from HNA screening to the State's enrollment broker, PMPs and other appropriate parties in accordance with State and Federal confidentiality regulations
- Coordinating care services in accordance with the member's PMP care plan
- Analyzing, tracking and reporting to the OMPP the issues related to children with special health care needs, including grievance and appeals data
- Participating in clinical studies of special health care needs as directed by the Hoosier Healthwise Clinical Studies Committee

On the 11th and 26th days of each month the fiscal agent runs an file that contains Additional Function Identifier (AFI) information which is used to identify persons with special health care needs. The files are made on File Exchange on the 12th and 27th days of each month.

Newborn Prebirth PMP Selection

A pregnant woman should be encouraged to select a PMP for her child prior to its birth. Because an unborn child does not have an established record, the PMP selection is stored in Indiana*AIM* on the mother's record. After the child is born, the DFR caseworker must establish a record in ICES that is passed to Indiana*AIM*, which then establishes an auto-assignment link to the preselected PMP retroactive to the date of birth. This occurs when both of the following conditions are present:

- The mother was enrolled in the MCO on the date of delivery
- The mother and the preselected PMP are in the same MCO network

A mother must choose a PMP for her unborn child from the MCO network in which she is enrolled. When the child is born and eligibility is established, the child is auto-assigned to the preselected PMP. If the preselected PMP is not available the baby is assigned to another PMP in the mother's MCO network. Assignments to MCO PMPs are retroactive to the date of birth.

Auto-Assignment

Occasionally, an IHCP member eligible for Hoosier Healthwise does not receive the initial program education or for some other reason fails to self-select a PMP within the first 30 days of eligibility. Because enrollment in the program is mandatory for most people who are eligible, after the first 30 days of program eligibility enrollment is accomplished by a PMP assignment in the auto-assignment process logic contained in Indiana*AIM*. Auto-assignment is designed to consider several factors in linking a member to an appropriate PMP. Figures 7.2, 7.3, and 7.4 provide a high level description of the logic hierarchy used in the auto-assignment process.

Auto-Assignment Process

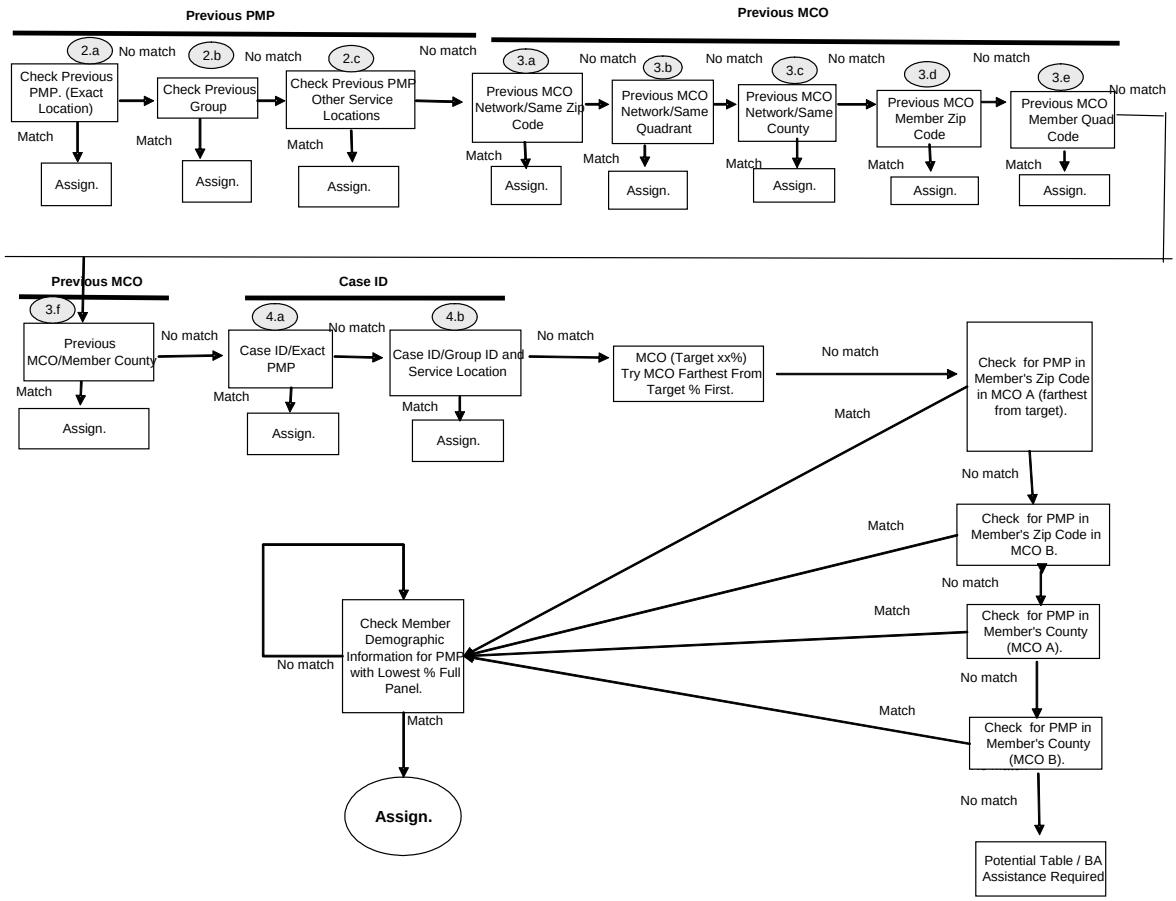

Figure 7.2

Figure 7.2 – Logic Hierarchy for Auto-assignment Process MCO Target

Auto-Assignment Process (continued)

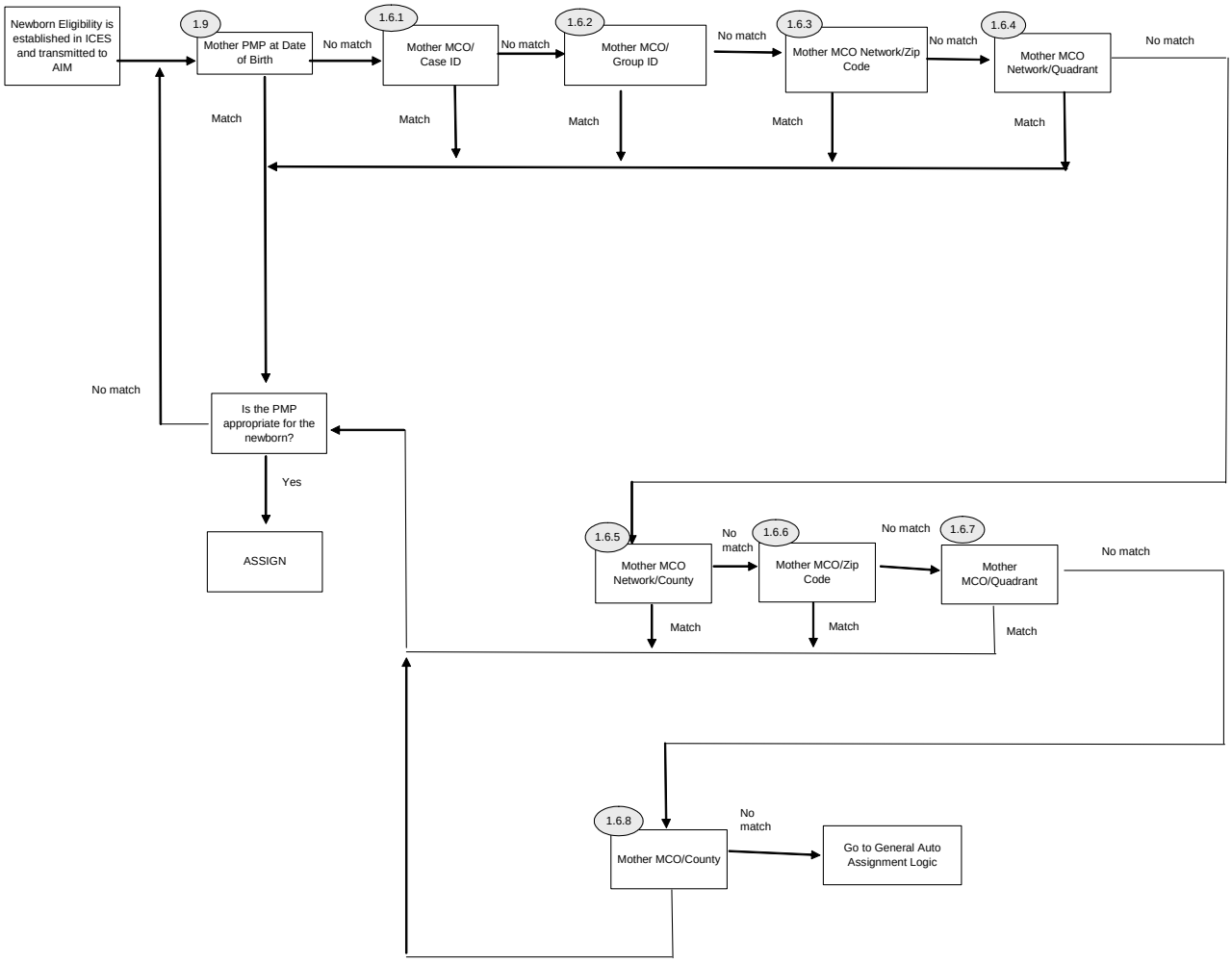

Figure 7.3 – Logic Hierarchy for Auto-Assignment Process Newborn Target

1. *Newborns* – A newborn's pre-selected PMP assignment (made by a MCO-enrolled mother) is retroactive to the date of birth. The enrollment broker does not allow an MCO-enrolled mother to select a PMP outside the MCO for a newborn preselection. An MCO-enrolled mother can request a PMP change after the birth of her child. This assignment will have a future effective date. The MCO retains responsibility for the newborn from the date of birth until the effective date of the PMP change out of the plan. Newborns whose MCO-enrolled mothers have not preselected a PMP are matched against several factors to determine the PMP with whom the newborn is auto assigned.

    a. *Mother's PMP at time of birth* – If a mother is not enrolled with a MCO at the time of birth, but becomes effective with a MCO when the newborn's record passes from ICES, auto-assignment will be attempted to the mother's PMP, but with a start date of the 1st or 15th of that month. If the mother is enrolled with a MCO at the time of birth, auto-assignment will be attempted to the mother's PMP with a start date the same as the child's date of birth.
    b. *Mother's MCO at time of birth* – If the newborn's mother was effective within a MCO when the newborn's record passes from ICES, auto-assignment will be attempted to a PMP within the mother's MCO. Auto-assignment encounters the following logic until a successful PMP assignment is made:

        1. *Case ID (Family Relationships)* – PMPs for family member with the same case ID is identified. If there is an appropriate PMP for the newborn, then an assignment is made.
        2. *Group ID* – PMPs that are in the same group as the mother's PMP are identified. If there is an appropriate PMP for the newborn in the group, then an assignment is made.
        3. *Mother's Network/ZIP Code* – PMPs that are in the mother's network (where applicable) and mother's ZIPcode are identified. If there is an appropriate PMP for the newborn, then an assignment is made.
        4. *Mother's Network/Quadrant* – (Only in Marion and Lake counties) PMPs that are in the mother's network (where applicable) and in an adjacent ZIP code are identified. If there is an appropriate PMP for the newborn, then an assignment is made.
        5. *Mother's Network/County* – PMPs that are in the mother's network (where applicable) and the mother's county are identified. If there is an appropriate PMP for the newborn, then an assignment ismade.
        6. *Mother's MCO/ZIPCode* – PMPs that are in the mother's MCO and the mother's ZIPcode are identified. If there is an appropriate PMP for the newborn, then an assignment is made.
        7. *Mother's MCO/Quadrant* – (Only in Marion and Lake counties) PMPs that are in the mother's MCO and in an adjacent ZIP code are identified. If there is an appropriate PMP for the newborn, then an assignment is made.
        8. *Mother's MCO/County* – PMPs that are in the mother's MCO and the mother's county are identified. If there is an appropriate PMP for the newborn, then an assignment is made.

If no PMP match can be made at the newborn level the logic attempta to auto-assign the member using the general auto-assignment logic.

2. *Previous PMP* – A Hoosier Healthwise member, who had been assigned to a PMP that is currently enrolled in the program, is reassigned to that PMP if the appropriate scope of practice and restrictions apply. Because continuity of care is one of the cornerstones of the Hoosier Healthwise program, the reassignment of members to their previous PMP takes precedence over other auto-assignment logic in Indiana*AIM*. This logic takes precedence over the PMP panel size limits, and allows auto-assignment to the full panel of a previous PMP. Assignments to the previous PMP and PMP by case ID are the only instances in which geographical boundaries are not considered.

Assignments to the previous PMP are made without regard to county and regional boundaries. The previous PMP auto-assignment logic considers the following when making an assignment determination:

a. *Exact PMP Service Location* – If the member's previous PMP is found at the same service location where the member was previously assigned then the assignment will be made.

b. *Previous Group* – If there is an appropriate PMP in the member's previous group at the member's previous PMP's service location, then the assignment will be made.

c. *PMP's Other Service Locations* – If the member's previous PMP is found at a different service location then the assignment will be made.

3. *Previous MCO* – If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with a currently-enrolled MCO. The system then attempts to assign the member to an appropriate PMP in the network in which the member may have a previously established case management history and familiarity with the network. The previous MCO auto-assignment logic considers the following when making an assignment determination:

   a. *Previous Network/Same ZIP Code* – PMPs that are in the member's previous MCO network (where applicable) and ZIP code are identified. If there is an appropriate PMP for the member, then an assignment is made.

   b. *Network/Same Quadrant* – (Only in Marion and Lake counties) PMPs that are in the member's previous MCO network (where applicable) and in an adjacent ZIP code are identified. If there is an appropriate PMP for the member, then an assignment is made.

   c. *Network/Same County* – PMPs that are in the member's previous MCO network (where applicable) and the member's county are identified. If there is an appropriate PMP for the member, then an assignment is made.

   d. *Zip Code* – PMPs that are in the member's previous MCO and ZIP code are identified. If there is an appropriate PMP for the member, then an assignment is made.

   e. *Quadrant* – (Only in Marion and Lake counties) PMPs that are in the member's previous MCO and in an adjacent ZIP code are identified. If there is an appropriate PMP for the member, then an assignment is made.

   f. *County* – PMPs that are in the member's previous MCO and county are identified. If there is an appropriate PMP for the member, then an assignment is made.

If an appropriate PMP is not found in the previous MCO in the member's ZIP code or county, the process moves to case ID logic, and then to default logic.

4. *Case ID (Family Relationships)* – For members other than newborns who do not have a previous MCO relationship on file, the system searches for a PMP based on the relationship of other family members, searching for a case ID match first, and then for appropriateness within the scope of practice restrictions. The caseworker in the local county office of Family Resources assigns a case identification number to all family members living in the same household at the time of determination or redetermination. Family members who do not live in the same household or who may have different guardians may have different case ID numbers. The case ID auto-assignment logic considers the following when making an assignment determination:

   a. *Exact PMP* – Active PMPs for all family members with the same case ID are identified. If there is an appropriate PMP for the member, then an assignment is made.

   b. *Group ID and Service Location* – PMPs that share the same group ID and service location as the PMP for the family member's with the same case ID are identified. If there is an appropriate PMP for the member, then an assignment is made.

5. *Default* – In the absence of a previous PMP, MCO, or case identification relationship, auto-assignment logic attempts to make an appropriate PMP assignment. The default level of the auto-assignment logic attempts to establish and maintain equal memberships between the MCOs within a region, and then between the PMPs within the plans.
6. After the default auto-assignment logic has identified the MCO and the network furthest away from its target percentage, the default logic attempts to find an appropriate PMP within that plan in the same ZIP code as the member's residence. If an appropriate PMP is not located within the member's ZIP code in the targeted MCO, the logic moves to the PMPs within the member's ZIP code in the MCO second furthest from their target percentage.
7. When an appropriate PMP match is not made in any available plan in the member's ZIP code, the process returns to the originally-targeted MCO and attempts to find an appropriate PMP in the same county as the member's residence. The exception to the county logic occurs in Marion and Lake counties where the logic first looks for an appropriate PMP in the same county quadrant as the member's residence before proceeding to the county level. The process continues to look for an appropriate PMP at the county level in each available plan.
8. At any point during steps six and seven in which there are available PMPs, the system attempts assignment to the PMP with the lowest percentage of filled panel size. For example, if the targeted plan has two PMPs (PMP A and PMP B) in the member's ZIP code and PMP A enrolled with a desired panel size of 2,000 members with 200 assigned members, and PMP B enrolled with a desired panel size of 200 with 100 assigned members then auto-assignment attempts to make the assignment to PMP A. This is because PMPA is 90 percent away from the desired panel size while PMP B is 50 percent away from the desired panel size.
9. After the auto-assignment process has targeted the PMP farthest away from the desired panel size, the logic determines whether the assignment is appropriate based on the demographic characteristics of the member and the PMP contained in Indiana*AIM*. If the assignment to PMP A (described previously) is inappropriate based on the age, gender of the member, or the PMP's scope of practice restrictions, the process returns to Step 6 to find the PMP the next farthest from the desired panel size.
10. When the auto-assignment logic has searched all available plans in the member's county and has not found an appropriate PMP match, the member's name appears on a *BA Assistance Required* report to the enrollment broker. Members who cannot be matched to an appropriate PMP in the auto-assignment process must be manually assigned to an appropriate PMP. Members who are not manually assigned to a PMP remain enrolled in Traditional Medicaid (fee-for-service). The members also remain on the potential assignment table in Indiana*AIM* and are auto-assigned when an appropriate PMP becomes available in any plan.

Special Characteristics of Auto-Assignment

The rule for determination of auto assignment start date is as follows: If the day that the auto assignment is processed falls between the 1st and the 10th of the month then the PMP assignment start date will be the 15th of the current month. If the day that auto assignment is processed falls between the 11th and the 25th then the PMP assignment start date will be the 1st of the next month. If the day that the auto assignment is processed falls on or between the 26th and the end of the month then the PMP assignment start date will be the 15th of next month.

Auto assignment nuances are listed below:

1. *Previous PMP*
   - A PMP will have its *panel full* status overridden.
   - A PMP will have its *panel hold* status overridden.
   - Aid category to provider specialty edit does not apply

- A female member previously linked to an OB/GYN physician is relinked to the same physician if the all-women-indicator is on and she is not in a pregnancy aid category.
- A member must remain within the PMP's scope of practice.
- A member who lost Hoosier Healthwise eligibility and is re-entering the program after a gap in coverage is auto-assigned to the previous PMP if the assignment is still appropriate within the PMP's scope of practice (for example, the member has not reached an age outside the scope of practice during the gap in coverage). After a lapse in coverage, a member is linked to the prior PMP in the PMP's currently open MCO. A member who was previously assigned to the PMP in MCO (A) would be assigned to the same PMP in MCO (B) if that is the PMPs current open MCO.
- If the assignment remains appropriate for the PMP's scope of practice, a member who is auto-assigned to the previous PMP at the time of redetermination (with no lapse in coverage) remains in the same MCO, unless the PMP has disenrolled from the MCO.
- The auto-assignment previous PMP logic does not consider a member and physician relationship that may have existed outside of the member and PMP assignment in the Hoosier Healthwise managed care program.
- If a PMP disenrolls from a MCO or service location and has an active service location in the same or different MCO, the members who were linked to the PMP are auto-assigned to the same PMP in the new MCO or service location if the assignment is appropriate for the PMP's scope of practice criteria at the new service location

2. *Previous MCO*
   - All date logic looks at the current date instead of the auto assignment start date.
   - The panel size limit must be greater than actual panel size for a provider to be considered.
   - The panel hold indicator must not be active for a provider to be considered.
3. *Newborns*
   - If the mother does not have an assignment, then preselection is allowed.
   - RBMC newborns are assigned retroactive to the date of birth (DOB) only in the instance where the mother was enrolled in an MCO at the time of the newborn's birth and there is an appropriate PMP available in the network.
   - The newborn is assigned to the same MCO in which the mother was enrolled at the time of birth.
4. *Case Logic*
   - Uses same program to check PMPs as previous PMP logic; therefore, the rules are the same.
5. *Default*
   - MCOs targeted for auto assignment are viewed in target percent order.
   - The Panel size limit must be greater than actual panel size for a provider to be considered.
   - A panel hold must not be active for a provider to be considered.
   - Aid category to provider specialty editing occurs here.

Members who are in designated wards or fosters aid categories (MA-3, MA-4) or are identified as a ward or foster by a caseworker via ward code indicator are not auto-assigned. Instead, they are in a voluntary managed care designation. These members may choose PMPs, but are not auto assigned to PMPs. When a PMP disenrolls (this includes service location changes) these members must request relinkage (assignment) to their PMP if the PMP disenrolls or re-enrolls.

Eligibility Redetermination

Eligibility redetermination occurs at intervals determined by the DFR. Members whose IHCP eligibility is continuous and who do not change from a managed care aid category to a non-managed care aid category, maintain the PMP relationship.

Members who have had a gap in IHCP eligibility or managed care eligibility are processed as new members for auto-assignment purposes. That is, they are given 30 days to choose a PMP. If a PMP selection is not made at that time, the member is auto-assigned according to the criteria outlined. A previously-enrolled Hoosier Healthwise member who does not make a PMP change is auto-assigned to the previous PMP, if appropriate, to maintain that relationship. A redetermined member may make an authorized change at that time.

Member Request to Change PMP

Members may request a PMP change at any time. The enrollment broker tracks reasons for requesting a PMP change, and examples are:

- Access to care
  - Member moved out of area
  - PMP's office not accessible on public transportation or an IHCP-reimbursable transportation provider is not available in the service area
  - Member waits in the office for one hour or more for a scheduled appointment on two occasions
  - Member experiences excessive delay between request for appointment and scheduled appointment
  - Member experiences difficulty contacting the PMP for care after normal business hours
  - Continuity of care
  - Member has an ongoing relationship with a PMP other than the PMP to whom the member is currently assigned
  - The member's current PMP disenrolls from the Hoosier Healthwise program
  - The member is in late stages of pregnancy and wishes to continue care with the current doctor through the pregnancy
  - Member experiences issues with the quality of care or service provided by the current PMP
  - Member expresses dissatisfaction with treatment by doctor or staff
  - Member requires specialty services due to language, cultural, or other communication barriers with current PMP
  - Ongoing, unresolved provider or member conflict exists
  - Member no longer fits into provider's scope of practice
  - Member was auto-assigned to a PMP
  - Other

A detailed explanation must be submitted in writing, reviewed, and is approved on a case-by-case basis.

The enrollment broker maintains responsibility for administering and approving PMP change requests through the Hoosier Healthwise Helpline at 1-800-889-9949. The OMPP retains ultimate authority for approval of change criteria and for allowing PMP changes outside the approved guidelines when warranted by unusual circumstances. The OMPP monitors and addresses participants who have frequent PMP changes or who alternate frequently between MCO providers.

MCOs are responsible for approving PMP changes within their own networks. Then the MCOS must forward these changes to the enrollment broker to enter. The enrollment broker enters the change into Indiana*AIM*.

To ensure the accuracy of the PMP enrollment rosters and MCO capitation payments, PMP changes are effective only on the first day of a month. PMP changes entered into Indiana*AIM* by the 25th day of the previous month are effective the first day of the next month. Changes entered into the system after the 25th day of the month are not effective until the first day of the second month.

Provider-Initiated Requests for Member Reassignment

The goal of the Hoosier Healthwise program is to encourage a positive and continuous relationship between members and PMP. In rare instances, a PMP may request reassignment of a member to another PMP within the MCO's network. These situations must be documented and approved by the MCO for reasons such as:

- Missed appointments (with appropriate documentation and criteria)
- Member fraud (upper-level review required)
- Uncooperative or disruptive behavior resulting from the member or member's family (upper-level review required)
- Medical needs could be better met by a different PMP (upper-level review required)
- Breakdown in physician and patient relationship (upper-level review required)
- Member accesses care from providers other than the selected or assigned PMP (upper-level review required)
- Previously-approved termination
- Member insists on medically unnecessary medication

The MCO's medical director or a committee appointed by the medical director performs an *upper-level review*. It is a thorough review of the individual case to determine whether the cause and documentation are sufficient to approve a reassignment request. The upper level review includes monitoring to ensure consistency in the MCO's guidelines and policies with the Hoosier Healthwise program and to improve the overall program quality.

The following, developed and finalized by the Hoosier Healthwise QIC, provides guidelines for the situations outlined previously:

- *Missed appointments* – A member may miss at least three scheduled appointments without defensible reasons prior to a PMP request for member reassignment. The PMP or staff is responsible for educating the member about the problems and consequences associated with missed appointments on the first occurrence. Hoosier Healthwise members are not penalized for inability to leave work, lack of transportation, or other defensible reasons. Missed appointments must be documented in the member's chart accessible to the PMP and staff. On documentation of the third missed appointment for non-defensible reasons, the MCO may approve the PMP's request for the member's reassignment within the MCO network.

  MCOs are encouraged to have procedures in place to assist members and PMPs with missed appointment problems and are expected to intervene as required to resolve issues while supporting the overall goals of the Hoosier Healthwise program.

- *Member fraud* – This reason for member reassignment must be restricted to those cases referred to the Indiana Bureau of Investigation or the Office of the Inspector General.

- *Threatening, abusive, or hostile actions by members* – The PMP can request a member's reassignment when the member or the member's family becomes threatening, abusive, or hostile to the PMP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PMP's office policies and criteria used to request reassignment of commercial patients. The MCO must have conflict resolution procedures designed to address these concerns.

- *Member's medical needs will be better met by another PMP* – A PMP request for member reassignment because the PMP believes a member's medical needs would be better met by a different PMP must be documented as to the severity of the condition and reviewed by the MCO's medical director. The MCO medical director must review the request based on the specific

condition or severity of the condition as a PMP scope of practice matter not based on a bias against an individual member.

- *Breakdown of physician and patient relationship* – The MCO must conduct an upper-level review, as defined previously, to ensure the breakdown in the relationship is mutual between the PMP and the member.
- *Member accessing care from other than the selected or assigned PMP* – The MCO must conduct member education about the network and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a provider other than the PMP, the PMP may request the member's reassignment. Misuse of the emergency room is not a valid reason for requesting a member's reassignment.
- *Previously-approved termination* – The PMP may request a member's reassignment if the member was previously reassigned for an approved reason and became re-linked through the auto-assignment process.

Most of these situations can be resolved by facilitating the member's selection of another PMP within the network. Members who require services of a provider not available within the network generally are not disenrolled, but remain in the MCO network, with the MCO managing and reimbursing for out-of-network services.

> *Note: The enrollment broker must authorize provider or MCO-initiated PMP changes resulting in a member's disenrollment from the network.*

MCOs must use PMP-initiated requests for member reassignments to identify issues and concerns documented in quality improvement processes. Each MCO must develop an internal policy for approval of PMP-initiated member reassignments based on the broad criteria outlined previously. The policy must be submitted to the OMPP for approval.

Unacceptable Reasons for PMP-Initiated Member Transfer Requests

- *For good cause* – This term is used for member-initiated PMP change requests.
- *Noncompliance with mutually agreed to treatment* – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- *Demand for unnecessary care* – A PMP-initiated request for member reassignment will not be approved for this reason unless there is documentation of threatening, abusive, or hostile behavior as described.
- *Language and cultural barriers* – PMPs who have difficulty with a member's language or other cultural barriers must request assistance from the MCO network resources to address the problem.
- *Unpaid bills incurred prior to Hoosier Healthwise enrollment* – PMPs may not initiate member transfer requests because of unpaid medical bills incurred prior to Hoosier Healthwise enrollment. PMPs can pursue charges outstanding prior to Hoosier Healthwise enrollment through the normal collection process.

Member Disenrollment from Hoosier Healthwise

The following are causes for which a Hoosier Healthwise member can be disenrolled from the IHCP and Hoosier Healthwise programs:

- Member was enrolled in error or due to data entry error

- Member loses eligibility in IHCP

An MCO enrollee may disenroll from an MCO network while retaining eligibility in the Hoosier Healthwise program. Member disenrollment from an MCO network with enrollment into another MCO network occurs under any of the following circumstances:

- The member selects a PMP that is not in the MCO network
- The member selects a PMP with an open program segment in a different network
- The member's PMP disenrolls from the MCO network and is available to Hoosier Healthwise members in another network
- The disenrollment is approved by the OMPP due to circumstances which, in the judgment of the OMPP, are justified and documented

Some instances may warrant a member's disenrollment from the Hoosier Healthwise managed care program while eligibility is maintained in another IHCP component. It is important to program integrity that criteria used to make this determination are valid reasons for disenrollment and are applied consistently for all program enrollees. The enrollment broker approves, monitors, and tracks all member disenrollment activity for quality improvement through its Hoosier Healthwise Helpline at 1-800-889-9949. The OMPP has ultimate authority for allowing eligible members to disenroll from the program.

Examples of acceptable reasons for member disenrollment from the Hoosier Healthwise managed care program to participate in another IHCP program include but are not limited to the following:

- Member is determined to be ineligible for the program under the terms of the state of Indiana 1915(b) waiver.
- Change in aid category causes enrolled member to become ineligible for managed care.
- Residency change causes enrolled member to become ineligible for managed care. Hoosier Healthwise members who have out-of-state addresses are identified on a monthly report produced by EDS. The fiscal agent forwards this report to the enrollment broker, which manually disenrolls the members. The former Hoosier Healthwise members can retain IHCP eligibility during a defined notification period as required in the Indiana Administrative Code (IAC). Disenrollment from Hoosier Healthwise prevents further payment of administrative fees and capitation during this notification period.
- Enrolled member meets long-term care criteria as determined by the Indiana Pre-Admission Screening and the Federal Pre-Admission Screening (IPAS/PASRR) processes. Hoosier Healthwise members who are in a long-term care facility for more than 60 days can be disenrolled from the program because MCOs are not financially responsible for long-term facility care. After a member has met IPAS/PASRR, the appropriate level of care is entered into Indiana*AIM*, and the member is disenrolled from Hoosier Healthwise. Long-term care facilities must notify the MCO immediately after becoming aware of an MCO enrollee who is undergoing the screening process for long-term admission. The MCO must notify the enrollment broker to disenroll the member at the end of the month. The MCO is financially responsible for all ancillary services and hospital care until the disenrollment is effective. The IHCP fee-for-service is financially responsible for all long-term care charges, excluding ancillary services, if the member meets the criteria for long-term level-of-care. MCOs must monitor the care of members who are potential candidates for long-term care so they can help facilitate disenrollment from managed care. The MCO must work with the facility to ensure that the level of care process is completed (for example, submit the Form 450B). Otherwise the member may be re-enrolled into managed care due to incomplete documentation for level of care.
- Enrolled member is a ward or foster child whose legal guardian requests disenrollment from the program. Wards and foster children in aid categories MA 3 and MA 4 may select a PMP and

participate in the Hoosier Healthwise program on a voluntary basis. Wards and foster children who are in other aid categories can be auto-assigned in the Hoosier Healthwise program and must be encouraged to remain in the program when feasible. Members who are placed in group homes within Indiana or out-of-state must be disenrolled from Hoosier Healthwise on request to facilitate access to care in the current setting.

- Enrolled member becomes eligible for and enrolls in a HCBS waiver program. Hoosier Healthwise members can become eligible for HCBS waiver services. Because IHCP enrollees can participate in only one waiver program at a time, Hoosier Healthwise members who participate in another waiver program can request disenrollment from Hoosier Healthwise. MCOs that become aware of this circumstance must contact the Hoosier Healthwise Helpline at 1-800-889-9949 to begin the disenrollment process.
- Enrolled member becomes eligible for and enrolls in the IHCP hospice program. To receive hospice benefits, a member must elect hospice services, the attending physician must make a certification of terminal illness, and a plan of care must be in place. At the time a Hoosier Healthwise member elects to enroll in the IHCP hospice program the member must be disenrolled from Hoosier Healthwise so the appropriate level of care can be entered in Indiana*AIM*. The hospice analyst at HCE requests that the enrollment broker immediately disenroll the Hoosier Healthwise member. The enrollment broker notifies the MCO and the PMP in writing of the member's disenrollment effective the day following MCO and PMP notification. The member becomes eligible for hospice care on the managed care disenrollment effective date. This process ensures that both the MCO and the hospice providers have an accurate effective date on which to end or begin services.
- Enrolled member who becomes eligible for Medicare is no longer eligible to participate in the Hoosier Healthwise program.
- Member who has other medical coverage in a managed care plan may be required to select a PMP in that network. If the PMP in the commercial network is not in a Hoosier Healthwise network and coordination of benefits is not appropriate due to a documented reason or circumstance, the member can be disenrolled from Hoosier Healthwise and placed in the IHCP fee-for-service program.
- Enrolled member who is determined to be an undocumented person is limited to emergency services under IHCP Package E.
- Other enrolled members as determined by the OMPP.

Restricting Disenrollment

Federal regulation *42 CFR 438.56* allows Medicaid programs the option of extending lock-in periods up to 12 months. However, if a state elects to implement a 12-month lock-in, certain other requirements apply as follows: Members must be allowed to change managed-care entities for cause at any time within the first 90 days of enrollment for no reason and the members must be notified, at least 60 days prior to the end of the enrollment year, of their opportunity to change after 12 months. The definition of *managed care entity*, as applied to Hoosier Healthwise, is an MCO.

Member Enrollment Rosters

On behalf of the OMPP, EDS notifies each MCO of all members enrolled in its network by region. Using information obtained from the State's ICES transmissions and PMP assignments entered in Indiana*AIM* during member enrollment and the auto-assignment process, EDS generates semi-monthly 834 MCO benefit enrollment and maintenance transactions. Refer to the *Companion Guide for the 834 MCO Benefit Enrollment and Maintenance Transaction* for more information about this transaction..

The MCO member enrollment roster provides the MCO with a detailed list of member for whom the MCO is responsible. Change files are created twice a month, indicating new, termed or deleted members, or changes to continuing member records that have occurred since the previous change file was created. Audit files are created toward the end of each month listing all the members effective with the MCO and region as of the first of the following month. The member enrollment roster's segments are categorized as follows in the 834 change files:

- Continuing enrollees
- New enrollees
- Terminated enrollees
- Deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated prior to the actual effective date with the MCO
- Unpassed eligibility due to timing of the PMP change
- Worksheet summarizing the categories listed above

In addition to the eligibility status and demographic information, the MCO member enrollment roster includes an auto-assignment indicator and the First Steps eligibility indicator. The indicator is used to identify members who were auto-assigned regardless of the auto-assignment reason (previous PMP, case ID, default) described previously in this section. This indicator assists the MCO in identifying members who were auto-assigned and who may not have participated in the enrollment broker's education program provided to new Hoosier Healthwise members. MCOs can use this indicator to identify a target population for new member orientation or additional program education. The First Steps eligibility indicator is used to identify members who are active with the First Steps program. If a member is identified as active with the First Steps program the MCO member roster will also include the date they were effective and terminated from the First Steps program.

Monthly member enrollments are provided to the MCO in the following two segments:

- Managed care enrollments entered into Indiana*AIM* from the 11th through the 25th days of the month are processed on the 26th and available to the MCO in the early morning hours on the 27th of the month, listing members with effective dates on the first day of the following month.
- Managed care enrollments entered in Indiana*AIM* from the 26th day of the month through the 10th day of the following month are processed on the 11th and available to the MCO in the early morning hours on the 12th day of the month for members with effective dates on the 15th day of the current month.

Package C Member Eligibility

Eligibility for Hoosier Healthwise members enrolled in Package C is included on the 834 MCO transaction. MCOs can identify Package C members with different plans of benefits based on the member's benefit package indicator.

Discrepancies in Eligibility Reporting

Deleted Eligibility

Member data on enrollment rosters is current as of the day the rosters are produced. Because the enrollment rosters are produced semi-monthly, while Indiana*AIM* is updated with daily ICES transmissions, changes in enrollment may occur during the period between the production of the roster and the effective date. Some scenarios that cause eligibility reporting discrepancies follow.

Member Information Changes

A member may become ineligible before the effective date of enrollment with an MCO. For example, a member auto-assigned to the MCO on the 20th day of the month with an effective date on the first day of the following month appears on the 834 MCO change file produced on the 26th of the month. Because the member lost eligibility prior to the effective date in the MCO network the member is reported as a deleted member on the next 834 change file. MCOs must have a procedure to remove deleted members from their records.

When an MCO receives member information regarding a change in address or telephone number, the MCO must complete *State Form 44151, Report of Change*, and complete the MCO's internal procedure for updating the MCO's database. MCO's must use the blue form (*State Form 44151*) to report changes. The MCO must only complete thename of case, caseworker ID number, case number, change of address information, and phone number. Under the state seal, the MCO representative must write **Per client call to (Name of MCO) on (date)**, and the MCO representative must sign the form. After matching the member with the appropriate county, the MCO representative can use a prefabricated reference file or the Internet listing of the Division of Family Resources offices to submit changes directly to the local county office of Family Resources. MCO representatives must indicate the Division of Family Resources caseworker ID number on the address line of the envelope. This speeds up delivery to the correct Division of Family Resources caseworker.

The change form for Hoosier Healthwise members whose coding identifies them with a Marion County Office, Division of Family Resources must be submitted to the administrative office at the following address:

Marion County Office of Family Resources/Department of Child Services
129 E. Market St., Suite 1200
Indianapolis, IN 46204

This office uses courier service to the other Marion County Office, Division of Family Resources locations daily.

The change form for Hoosier Healthwise members whose coding identifies them as Lake county residents, must be submitted to the administrative office at the following address:

Lake County Office of Family Resources/Department of Child Services
661 Broadway
Gary, IN 46402

MCOs can obtain *State Form 44151, Report of Change*, by faxing a request on an official MCO letterhead to the State Forms Distribution Center at (317) 591-5333. There is no charge for the forms, which are issued in packages of 100.

Hard copy requests *instead* of faxed orders can be mailed to:

Forms Distribution
6400 E. 30th Street
Indianapolis, IN 46219

Note: Do not send both fax and mailed requests for forms.

Electronic Transmission of MCO Member Eligibility Rosters

The MCO 834 benefit enrollment and maintenance transactions are available twice monthly to MCOs on File Exchange. To exchange data with the IHCP using File Exchange, trading partners are required to have an Internet service provider and secure file transfer protocol (SFTP) client software. Users may access File Exchange 24 hours a day, seven days a week.

The jobs that create the enrollment rosters always run on the evening of the 11th (Chang File) and 26th (Change and Audit Files) of every month. Files and summary reports are available for download from the File Exchange during the early morning hours of the 12th and 27th of each month.

Eligibility Verification

As described previously, MCOs receive twice monthly enrollment transactions for new, changed, and terminated members assigned to their plans.

Enrollment transactions reflect members' status in Indiana*AIM* as of the day the roster was produced. As explained earlier this section, ICES eligibility is updated in Indiana*AIM* daily. The eligibility verification options described in the following subsections are updated with the daily ICES information; therefore, they contain the most current eligibility status. MCOs must advise providers to *verify member eligibility each time a service is rendered*. Failure to verify eligibility may result in a provider rendering services to an ineligible member. All of the eligibility verification systems described provide an inquiry verification number that must be recorded in the event it is required for subsequent transactions. MCOs must assume all telecommunication and hardware costs associated with these systems.

Eligibility Verification System

Using this option, eligibility verification is accomplished in a real time, interactive mode using one of the eligibility verification systems (EVS), such as the Automated Voice-Response System (AVR), Point-of-Service Terminal Device (POS), or Web interChange.

After the user enters the provider number, the member ID number, and the from and through dates of service, eligibility information is transmitted online. Additionally, the EVS generates the member's PMP name and phone number along with the MCO name, MCO phone number, MCO network (if applicable), and MCO network phone number (if applicable).

Section 8: Network Development, Services, and Data

Provider Network and Specialties

Physicians with these specialties can apply for enrollment as a primary medical provider (PMP):

- Family practitioner
- General practitioner
- OB/GYN
- General pediatrician
- General internist

> *Note: Physicians must be enrolled in the IHCP at the service location where they wish to practice as a PMP before contracting with a Managed Care Organization (MCO) to be a PMP.*

The Office of Medicaid Policy and Planning (OMPP) can, at its discretion, recognize other specialty areas that may serve in the PMP role. Enrollment of physicians outside these specialties as PMPs is approved by the OMPP, as necessary to accommodate an individual Hoosier Healthwise member or potential member.

In addition to PMPs enrolled with the specialties listed above, the Managed Care Organization (MCO) must have a regional provider network comprised of specialists, ancillary providers, and Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories as well as inpatient and outpatient facilities. The network must make a good faith effort to contract with acute care hospitals in its service area. The network must be sufficient to provide all services available to Hoosier Healthwise MCO members.

The network consists of providers directly contracted or subcontracted with the MCO. The MCO must provide members with a network directory upon enrollment and upon request. The directory must include PMPs, specialists, inpatient and outpatient providers, pharmacies, home health agencies, durable medical equipment services, transportation services, laboratory services, and self-referral services. The directory must also include the names, addresses or geographic locations, phone numbers, office hours, description of office accessibility, spoken languages, and types of physicians, including certification and scope of practice. The network directory must be updated monthly, or as needed, using addenda or reprints.

Specialty providers participating in Hoosier Healthwise may contract with all of the MCOs. Unlike PMPs, specialist and ancillary providers are not limited to serve in only one MCO network. In addition, physicians contracted as a PMP with one MCO may contract as a specialist with the other Hoosier Healthwise plans.

The OMPP encourages each MCO to develop a comprehensive network of specialty providers throughout the State. However, the MCO network in each county must include, at a minimum:

- Two specialty providers of each provider type listed below who have locations of service in each county; or

- A combination of two specialty providers for each type listed below in any one of the following combinations:
  - One of each type of specialty provider with a service location in each county, and
  - One of each type of specialty provider with a service location in a county contiguous to the county, or
  - One of each type of specialty provider with a service location in a county within 60 miles or 60 minutes from the member's residence ZIP code

The MCO must include a minimum of two specialists and ancillary providers of each type identified below for each county within the access standards described above:

- Physician specialties
  - Cardiologist
  - Orthopedic surgeon
  - Otologist or otolaryngologist
  - Urologist
- Self-referral Practitioners
  - Chiropractor
  - Family Planning practitioner
  - Ophthalmologist or optometrist
  - Podiatrist
- Ancillary Providers
  - Durable medical equipment (DME) provider
  - Home health
  - Pharmacy

Considering the nature of the services some ancillary providers render, the OMPP requires each MCO maintain different network access standards for the following providers:

- Two durable medical equipment providers and two home health providers must be available to provide services to the MCO's members in each county
- Two pharmacy providers must be within 30 miles or 30 minutes from a member's residence in each county

The MCO must contract with the Indiana Hemophilia and Thrombosis Center or a similar federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally-recognized treatment center require less hospitalizations, experience less bleeding episodes and experience 40 percent reduction in morbidity and mortality.

The MCO must arrange for laboratory services only through those IHCP-enrolled laboratories with CLIA certificates.

The MCO must contract its specialist and ancillary provider network prior to receiving enrollment in a mandatory RBMC county. The OMPP reserves the right to implement corrective actions or liquidated damages as described in this policy if the MCO fails to meet and maintain the specialist and ancillary provider network access standards. The OMPP's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the MCO until the MCO's specialist and ancillary provider network is in place. The OMPP monitors the MCO's specialist and ancillary provider network to confirm the MCO is maintaining the required level of access to specialty care. The OMPP reserves the right to increase the number or types of required specialty providers at any time.

The OMPP may elect to establish and apply a non-financial incentive for an MCO that expands its network to include additional specialists with a service location in each county or are accessible under the alternate access standards. These additional specialists include:

- Allergist
- Endocrinologist
- Gastroenterologist
- Nephrologists
- Neurologist
- Obstetrician (non-PMP)
- Oncologist
- Pediatrician (non-PMP)
- Pulmonologist
- Thoracic surgeon

The MCO must arrange for and reimburse out-of-network IHCP providers for services not available within the MCO network. The MCO must demonstrate that the network has sufficient capacity, as determined by the OMPP, to handle the projected number of Hoosier Healthwise members during readiness reviews and throughout the contract with the OMPP.

Regional Network Development

On the effective date of the contract, the MCO must have a regional provider network comprised of PMPs, specialists, and ancillary providers as well as inpatient and outpatient facilities. This network may consist of providers contracted or subcontracted with the MCO. The OMPP, or its contractor, conducts a readiness review of the provider network prior to the effective date of the MCO contract.

The MCO must consider the following in developing a regional network that renders services to members in Hoosier Healthwise:

- Anticipated enrollment
- Access to care within the network location of PMP service sites, travel time, availability of public transportation services, or other factors affecting accessibility to care in a given service area
- Response to the cultural, racial, and linguistic needs of the population
- Assessment of the number and type of primary medical providers accepting newly enrolled members.
- Detailed process for credentialing and recredentialing providers to ensure that provision of quality care is maintained
- Access to a specialty and hospital network, as well as plans for provision of medically necessary non-contracted specialty care out of the network
- Provision of ancillary services, including dental care, transportation, durable medical equipment, pharmacy services, and home health care

Regional Network Development Plan

Additional service areas in provider network development can be required in the Hoosier Healthwise MCO. The MCO must provide a comprehensive plan for network development throughout each contracted region. The plan must detail targeted areas for development and prioritization of those targeted areas, explain how development will be accomplished, and establish time lines for implementation, including provider education, outreach, and staff training. The plan must be updated quarterly and forwarded to the OMPP for review and comment.

The MCO must describe the number of PMPs accepting patients newly enrolled in Hoosier Healthwise, their locations and numbers, and the type of primary care physicians (such as, family practice, general practitioner, internist, pediatrician, and OB/GYN). This description of PMPs accepting new patients provides information to track providers who have met the maximum panel size and, more importantly, those who have not met the minimum. This description assists the MCO in targeting geographical areas for network development.

The MCO must have established provider networks of geographically accessible locations for the Hoosier Healthwise MCO population to be served. Accessibility to hospitals, physicians, pharmacies, transportation services, and so forth, must be demonstrated by the MCO.

The MCO must document a complete description of the provider network available to enrollees. There must be a plan that ensures selected PMPs are accessible, taking into account travel time and the availability of mass transit for enrollees.

The MCO must present a detailed plan for provision of ancillary services. The plan must include assurance of adequate access to ancillary services such as transportation services, durable medical equipment services, pharmacy services, and home health services.

The network development plan must also include, but is not limited to, the following:

- Goals and objectives
- Gantt chart, including a list of network development tasks, associated time frames, and responsible staff positions
- Job descriptions and qualifications of staff involved with network development
- Copy and description of how the network development plan interacts with education and outreach, quality improvement, and financial stability
- Description of methods used for network development
- Description and copy of forms and plans used for the corrective action process
- Description of strategies used for recruiting in-network development, including staff positions and time frames
- Description of target areas for network development
- Reports that include number and type of providers enrolled and current provider-to-member ratios
- Evaluation plan of network development activities
- Physician incentive arrangements

The plan must establish numeric, geographic, and linguistic targets for all provider types (such as PMPs, specialists, and facilities) based on IHCP-eligible members and expected enrollments. The plan must detail targeted areas for development, prioritization of those targeted areas, explanation of how development will be accomplished, and established time lines for implementation. The plan must

include functions for evaluation of plan success or failure in achieving targets, resolution of problems in plan implementation, and plan modification based on updated projections.

When the physician elects to participate in the RBMC delivery system, he or she may only contract as a PMP with only one MCO. However, an MCO PMP may participate as a specialist in any other Hoosier Healthwise managed care plan.

The MCO must assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's care and make any referrals necessary. The MCO must track PMP referrals to specialists and emergency providers and provide information on PMP referrals upon request.

The MCO's PMP contract must state the PMP panel size limits, and the MCO must assess the PMP's non-Hoosier Healthwise practice when assessing the PMP's capacity to serve the MCO's members. The OMPP considers an appropriate average member-to-PMP ratio to be no more than 250 members to one PMP. The OMPP will monitor the MCO's PMP network to evaluate its member-to-PMP ratio on a quarterly basis

The MCO must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24-hours-a day, seven-days-a-week and that PMPs have a mechanism in place to ensure members are able to make direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free member services telephone number 24-hours-a-day, seven-days-a-week. The MCO must also ensure that PMPs are available to see members a minimum of 20 hours over a three-day period at any combination of sites. The MCO must also assess the PMP's non-Hoosier Healthwise practice to ensure that the PMP's Hoosier Healthwise population is receiving accessible services on an equal basis with the PMP's non-Hoosier Healthwise population.

The MCO must ensure that the PMP provide *live voice* coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The MCO must ensure that members have telephone access to their PMP in English and Spanish 24-hours-a-day, seven-days-a-week.

The MCO must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the *IHCP Provider Manual*. The OMPP will monitor medical care standards to evaluate access to care and quality of services provided to enrollees and to evaluate providers regarding their practice patterns.

Network Development Quarterly Reporting Requirements

The MCO must submit an updated network development report within 90 days of the MCO effective date, and quarterly thereafter, according to a schedule established by the OMPP. The *Quarterly Reporting* manual provides information about this report.

Network Development Reporting Requirements

The *Network Development Report* must include the following:

- Totals for the area:
  - Enrollment
  - PMPs (number, sum of panel sizes, and enrollment per PMP)
  - Hospitals
  - Pharmacies
  - Transportation providers
  - Home health providers

  - DME providers
  - Dentists (number and enrollment per dentist)
  - Laboratories
  - Agreements with Federally-Qualified Health Centers (FQHCs), Rural Health Clinica (RHCs), MCH clinics, and local health departments
  - Specialist by specialty (number and enrollment per specialty)
- By county in which the MCO has a presence:
  - Enrollment by county
  - PMPs (number, sum of the panel sizes, and enrollment per PMP)
  - Hospitals
  - Pharmacies
  - Transportation providers
  - Home health providers
  - DME providers
  - Dentists (number and enrollment per dentist)
  - Laboratories
  - Agreements with FQHCs, RHCs, MCH clinics, and local health departments
  - Specialist by specialty (number and enrollment per specialty)
- A list of any perceived network needs or providers targeted for development with a description of planned activities to provide remediation and anticipated completion dates, along with a goal level of each planned activity
- A count of provider disenrollments and reasons given

The Quality Improvement Committee (QIC) may make recommendations for additional reporting requirements. Additional reporting requirements can include the following:

- Identification of specific provider education and outreach activities (brochures, letters, and provider's staff education programs), method of distribution, completion dates, responsible staff, and required follow-up
- Identification of providers who do not comply with recommended preventive health standards and guidelines and improvement plans, responsible staff for each task, and time frames for provider compliance with these standards
- Access to care reports that include assessment of access standards
- List of PMPs, by county, who do not accept new members and reasons for not accepting new members, with documentation of education, outreach, and improvement plans to address identified trends
- Number of PMP site visits as a result of credentialing activities
- Number of out-of-network encounters by type and county
- Number of self-referral services provided by in-network and out-of-network providers
- Number and frequency of provider inquiries, by type of inquiry
- Number of provider grievances, resolved and unresolved
- Preventive health standards and guidelines distributed to MCO members during the reporting quarter and future quarters
- Perceived network needs for counties not targeted in the reporting quarters

If the MCO does not submit or comply with the network development plan requirements, the OMPP establishes a reasonable period of time in which the MCO must remedy noncompliance issues. The

State reserves the right to assess liquidated damages in the case of noncompliance with the submission or specific requirements of a network development plan within the established time period.

Provider Directory

The MCO must provide OMPP, the enrollment broker, and all Hoosier Healthwise members with the following information about its network providers:

- Lists of PMPs, the PMPs' service locations (including county), phone numbers, office hours, type of PMP (for example, family practice, general practitioners, general internists, general pediatricians, obstetricians and gynecologists) and whether the PMPs are accepting new members
- Lists of specialty providers, their service locations (including county), phone numbers, office hours, type of specialty
- Lists of hospital providers, pharmacies, home care providers and all other network providers
- Hours of operation for physicians and ancillary providers, including evening and weekend hours of operation
- Names of providers with ADA accessibility and indicate ADA assistance availability
- Provider office location's access along public transportation routes
- Languages spoken by the provider or the provider's office personnel

On a quarterly basis in accordance with a schedule set forth by OMPP, the MCO must also provide the OMPP's enrollment broker and fiscal agent an electronic data file containing information on the MCO's network of contracted providers. These files should include updates for the purpose of providing a program comparison guide for members and potential enrollees, as required by *42 CFR 438.10(e)*, as well as provide information for entry into Indiana*AIM*.

The MCO must include provider network information in an OMPP-approved format (currently Bobby format) on its member Web site. Provider network information on the MCO's Web site must be updated monthly and be available for users to print from a remote location.

Services Provided in Shelters for the Homeless

MCOs are encouraged to reimburse providers for services provided to enrollees in a shelter for the homeless or similar setting. While the shelter or the rendering provider may not be enrolled in the MCO network, MCOs are expected to consider lack of housing as a circumstance that can affect an enrollee's access to care, and preclude the enrollee or provider from obtaining the usual authorization.

Provider Network Data

After the MCO network providers are enrolled as IHCP providers, the MCO must notify the OMPP or its agent of all PMPs, specialists, and ancillary providers enrolled in the networks. Additionally, the MCO must maintain a process with the OMPP or its agent to transmit changes in provider status including, but not limited to provider additions, deletions, and opening or closing of practices. Data transmission must occur at least monthly or on a schedule to be determined by the OMPP. *Appendix G: PMP Disenrollment Timeline* provides a timetable for submission of paperwork and associated system change effective dates.

MCO Network Provider File

The *MCO Network Provider File* is a list of all specialists, facilities, and ancillary providers participating in the network. PMPs are not included in this file. It is important to note that the purpose of this file is not to enroll a provider, but to link currently enrolled providers to the MCO network. If a provider is not IHCP-enrolled, linked in Indiana*AIM* to an MCO group, or is ineligible for any reason, the fiscal agent (EDS) generates an exception list to the MCO giving the reason the provider record cannot be accepted. It is the responsibility of the MCO to contact the affected provider.

The MCO transmits its provider network information electronically to the fiscal agent (EDS) monthly. Indiana*AIM* is updated to reflect the MCO's most current provider network information. This monthly transmission contains the file that replaces the entire previous month's file. The OMPP or its agent determines schedules for submission of the network provider file.

Section 9: Quality Improvement Program and Performance Reporting

Total Quality Improvement

The following are the goals of the Hoosier Healthwise Managed Care Program:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Each Managed Care Organization (MCO) must develop, administer, monitor, and evaluate activities in a Quality Improvement (QI) program. All QI activities must serve to improve the access, quality, and cost-effectiveness of care delivered to Hoosier Healthwise members. The MCO's QI program must include activities by all providers in all types of settings, in accordance with the provisions specified in the following subsections in the MCO's contract. In addition, the MCO must have a Utilization Review (UR) program in place in accordance with the provisions.

Quality Improvement Program and Reporting

The MCO must establish an internal committee to monitor and evaluate QI activities. The committee, specifically named Quality Improvement Committee (QIC), must be representative of key management staff, MCO departments, and subcontractors, if appropriate. The MCO medical director is responsible for the coordination of the MCO's QI program.

The activities of the QI program must be designed and administered so that they lead to improvements in the MCO's functioning and delivery of health care, and to the extent possible, in the health outcomes of Hoosier Healthwise members.

Communication and activities between the MCOs and the OMPP include, but are not limited to the following:

- Meetings
- Reports
- Quality improvement measures and studies

The MCO must meet the requirements of *42 CFR 438 subpart D* and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its quality management program. In doing so, it shall include an assessment of quality and appropriateness of care provided to member with special needs, complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects and to produce new information on quality of care every year.

The MCO's Quality Management and Improvement Program must:

- Include developing and maintaining an annual quality improvement plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results, and assesses progress toward the goals.
- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines, and names of individuals responsible for completing each task.
- Incorporate an internal system for monitoring services, including clinically appropriate data collection and management for clinical studies, internal quality improvement activities, assessment of special needs population and other quality improvement activities requested by the OMPP.
- Participate appropriately in clinical studies, such as the Health Plan Employer Data and Information Set® (HEDIS®) measures and in other studies requested by OMPP, such as assessment of the quality and appropriateness of care provided to members, in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or Health Watch requirements.
- Collect measurement indicator data related to areas of clinical priority and quality of care. The Hoosier Healthwise Clinical Studies and the Quality Improvement Committees establish areas of clinical priority and indicators of care. These areas may vary from one year to the next, and they reflect the needs of the Hoosier Healthwise population. Examples of areas of clinical priority and measurement studies include:
  - Immunization rates
  - EPSDT service utilization
  - Prenatal care
  - Blood lead testing
  - Emergency room utilization
  - Access to care
  - Special needs care coordination and utilization
- Report any national performance measures developed by the Centers for Medicare and Medicaid Services (CMS). The MCO must develop an approach for meeting the desired performance levels established by the CMS upon release of the national performance measures, in accordance with *42 CFR 438.240(a)(2).*
- Establish procedures for collecting and assuring accuracy, validity, and reliability of performance measures that are consistent with protocols developed in the public or private sector. The CMS Web site contains an example of available protocols.

The MCO must conduct an audited HEDIS Survey and Consumer Assessment of Health Plans Survey (CAHPS) annually in its quality management and improvement activities per OMPP guidelines.

The OMPP encourages MCOs to participate in the Best Clinical and Administrative Practices (BCAP) Quality Framework initiative. BCAP is a proven method to improve quality within Medicaid managed care that the Center for Healthcare Strategies has developed.

Quality Management and Improvement Plan Requirements

The MCO's Quality Management and Improvement Committee, in collaboration with the MCO's medical director, must develop an annual Quality Management and Improvement Plan. The plan must identify the MCO's quality management goals and objectives and include a timeline of activities and assessments of progress toward meeting the goals. The MCO must submit its *Quality Management and Improvement Plan* to the OMPP annually and must be prepared to periodically report on its quality management activities to the Hoosier Healthwise Quality Improvement Committee.

Each MCO's *Quality Management and Improvement Plan* must:

- Establish program goals and objectives specific to the Hoosier Healthwise population to improve the MCO's functioning, improve the delivery of health care services, and improve health outcomes.
- Identify specific tasks, persons responsible, and timelines for completion for each activity.
- Demonstrate an effort toward implementing enrollee-targeted or PMP-targeted programs that result from areas for improvement identified through readiness reviews, focused studies, and internal quality improvement efforts.
- Demonstrate that its quality improvement program is integrated throughout the organization, and through any of its subcontractors when appropriate, for the purposes of assessment, evaluation, and implementation of modifications and changes.

The MCO must also develop an annual *Quality Management and Improvement Summary Report* that documents the previous year's quality management projects, problems, issues, assessment of its data collection and monitoring processes, performance results to its internal standards or targets, benchmarks or industry standards that have been identified by the OMPP, identification of corrective actions, and results of corrective actions. The *MCO Reporting Manual* contains more information about the annual *Quality Management and Improvement Summary Report.*

Additional quality improvement detail can be found in the Request for Proposals (RFP).

Utilization Management Program

The MCO must operate and maintain its own utilization management program in accordance with *42 CFR 438.210*. The MCO may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve its purpose. The MCO is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness, or condition.

The MCO must establish and maintain medical management criteria and practice guidelines in accordance with federal and state regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the MCO's members. The MCO must have sufficient staff with clinical expertise and training to use the utilization management criteria and practice guidelines in interpreting and applying the criteria and guidelines to the providers' requests for health care or service authorizations for the MCO's members. The guidelines must be reviewed and updated periodically, distributed to providers, and made available to members upon request.

The MCO is encouraged to monitor utilization through retrospective reviews. As part of the utilization review, the MCO must monitor utilization of preventive care services by members, such as EPSDT, well-child, HEDIS, and blood lead screening and testing; and access to preventive care, specifically to identify members who are not accessing preventive care services, as appropriate, and in accordance with preventive care standards (for example, American Academy of Pediatrics, American College of Obstetrics and Gynecology), during their enrollment period with the MCO. The MCO is responsible for conducting follow-up education to the identified members to ensure that preventive care services are accessed appropriately and in accordance with preventive care standards.

The MCO must maintain an efficient utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures in place that identifies instances of over- and under-utilization of emergency room services and other health care services, identifies aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care, and screening exams), ensures active participation of a utilization review committee, evaluates efficiency and appropriateness of service delivery, incorporates

subcontractor's performance data, facilitates program management and long-term quality, and identifies critical quality of care issues. The MCO must define service authorizations in a manner that at least includes a member's request for the provision of services. The MCO's utilization management program policies and procedures must include timeframes for the following:

- Completing initial requests for prior authorization of services
- Completing initial determinations of medical necessity
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity
- Notifying providers and members of the MCO's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying provider and members of the MCO's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The MCO must have policies and procedures in place that encourage all new members to have a primary medical provider (PMP) visit within 90 calendar days of member's effective date of enrollment. The OMPP will review the MCO's shadow claims to evaluate the effectiveness of the MCO's efforts to meet this target.

The MCO must submit utilization performance data and assessments of its medical necessity determinations, prior authorization processes and emergency room utilization management to the OMPP. The *MCO Reporting Manual* provides information about utilization reporting.

Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO must not provide incentives to utilization management staff for denying, limiting, or discontinuing medically necessary services.

As part of the utilization management function, the MCO must facilitate its PMPs' requests for authorization for primary and preventive care services and must assist the PMP in providing appropriate referral for specialty services. In accordance with federal regulations, the process for authorization of services must comply with the following requirements:

- *Second Opinions:* In accordance with *42 CFR 438.206(b)(3),* the MCO must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the MCO must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.
- *Special Needs:* In accordance with *42 CFR 438.208(c),* the MCO must allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs
- *Women's Health:* In accordance with *42 CFR 438.206(b)(2),* the MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The MCO must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits.

The MCO must notify the requesting provider and provide a written notice to the member of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice to the member must be given within the timeframes required in this section and *42 CFR 438.404(c)*. If the MCO does not make a decision with the required timeframe, the MCO must notify the member on the last day of the timeframe that it has not made a decision. An untimely decision constitutes a denial and is considered adverse action.

The OMPP must approve all notification form letters used by the MCO. The letters must meet the requirements of *42 CFR 438.10(c) and (d) and Section 3.2* of the RFP regarding language, oral interpretation, and format for member materials, and must clearly explain the following:

- The action the MCO or its contractor has taken or intends to take
- The reasons for the action
- The member's right to file an appeal and the process for doing so
- If the member has exhausted the MCO's appeal process, the member's right to request a Family and Social Services Administration (FSSA) Hearing and the process for doing so
- Circumstances under which expedited resolution is available and how to request it
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services.

The MCO must notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed 10 calendar days after the request for services. An extension of as many as 14 calendar days is permitted if the member or provider requests an extension or if the MCO justifies to the State a need for more information and explains how the extension is in the member's best interest. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

For situations in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service. The MCO may extend the three working days to as many as 14 calendar days if the member requests an extension or the MCO justifies a need for additional information and how the extension is in the best interest of the member.

The MCO must notify the member of a decision to deny payment on the date of the MCO's decision if the member is liable for payment.

The MCO must notify members of decisions to terminate, suspend, or reduce previously authorized Hoosier Healthwise-covered services at least ten calendar days before the date of action, with the following exceptions:

- Notice is shortened to five calendar days if probable member fraud is verified
- Notice may occur no later than the date of the action in the event of:
  - The death of a member;
  - The MCO's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information;
  - The member's admission to an institution and consequential ineligibility for further services;
  - The member's address is unknown and mail directed to him/her has no forwarding address;
  - The member's acceptance for Medicaid services by another local jurisdiction;
  - The member's physician prescribes the change in the level of medical care;

  - An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or
  - The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the nursing facility for 30 days (applies only to adverse actions for nursing facility transfers).

Objection on Moral or Religious Grounds

If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with *42 CFR 438.102(b):*

- To the State with its application for a Hoosier Healthwise contract
- To the State if it adopts the policy during the term of the contract
- To potential members before and during enrollment
- To members within 90 calendar days after adopting the policy with respect to any particular service

Utilization Management Committee

The MCO must have a utilization management committee directed by the MCO's medical director. The committee is responsible for the following:

- Monitoring the MCO's provider's requests for rendering medically appropriate and necessary health care services to its members
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task
- Confirming the MCO has an effective mechanism in place to respond within one hour to all emergency room providers 24-hours-a-day, seven-days-a-week:
  - After the MCO's member's initial emergency room screening
  - After the MCO's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

The OMPP may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The MCO may be required to comply with such waivers and will be provided with prior notice by OMPP.

Program Integrity Plan

Pursuant to *42 CFR 438.601 and 438.610,* the MCO must have a written program integrity plan that describes in detail the manner in which it will detect fraud and abuse. The MCO must submit this plan as part of the readiness review for OMPP's approval. This plan must be updated annually and submitted to OMPP as part of the MCO's *Quality Management and Improvement Summary Report.*

In addition to the federal requirements, the MCO must include the following in its Program Integrity Plan:

- Identification of persons who will be responsible for monitoring the contracting process between the MCO and its subcontractors
- The type and frequency of training and education for the compliance office and the organization's employees who will be provided to detect fraud

The MCO must immediately report to the Indiana Medicaid Fraud Control Unit (IMFCU) and the OMPP any suspicion or knowledge of fraud and abuse, including but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The MCO must not attempt to investigate or resolve the reported suspicion, knowledge, or action without informing the IMFCU and the OMPP and must cooperate fully in any investigation by the IMFCU or subsequent legal action that may result from such an investigation.

If subsequent investigation or legal action results in a monetary recovery to the OMPP, the reporting MCO must be entitled to share in such recovery following final resolution of the matter (settlement agreement or final court judgment) and following payment of recovered funds to the state of Indiana. The MCO's share of recovery must be as follows:

- From the recovery, the State (including the IMFCU) must retain its costs of pursuing the action, and its actual documented loss (if any). The State must pay to the MCO the remainder of the recovery, not to exceed the MCO's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.
- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State must exercise its best efforts to consult with the MCO about potential settlement. The State may consider the MCO's preferences or opinions about acceptance, rejection, or the terms of a settlement, but they are not binding on the State.
- If final resolution of a matter does not occur until after the contract has expired, the preceding terms concerning disposition of any recovery and consultation with the MCO must survive expiration of the contract and remain in effect until final resolution of a matter referred to the IMFCU by the MCO under this section.

If the State makes a recovery in a matter where the MCO has sustained a documented loss but the case did not result from a referral made by the MCO, the recovery must be distributed in accordance with the terms of this section.

As part of the annual *Quality Management and Improvement Program Plan Summary Report*, the MCO must submit a *Program Integrity Activities Summary* detailing the MCO's internal monitoring and auditing activities related to fraud and abuse that the MCO initiated during the past year. The summary must include a review of the fraud and abuse activities, as well as corrective action plans associated with these activities, outcomes of the corrective actions and planned activities for the upcoming year that will reinforce the corrective actions of the previous year.

Medical Management Standard Compliance

The health plan also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the plan's medical management standards.

The MCO must conduct a periodic review of claims files and medical audits to determine the following:

- Treatment was consistent with diagnosis

- Treatment resulted in appropriate outcomes for participants with certain high-risk chronic or acute conditions (for example, asthma, hypertension, diabetes, otitis media, lead poisoning, drug dependency, and diseases preventable by routine immunization)
- Services provided emphasized preventive care and resulted in early detection
- PMP referred members for specialty care appropriately
- Other compliance and appropriateness of services provided

In addition, the OMPP recommends that MCOs implement an internal desk review procedure. Utilization review is emphasized particularly for outlier cases.

MCOs are required to provide the OMPP with additional information to assist in investigation of outlier and other unusual cases.

MCO Monitoring Contractor

Federal Monitoring Requirements

The *Balanced Budget Act of 1997* (*BBA*) requires states contracting with MCOs to develop a "quality assessment and improvement strategy." The strategy is to include procedures for evaluating the quality and appropriateness of care and services. The BBA requires an annual independent review of any MCO contracting with the state's Medicaid program and requires that the review be conducted by a *qualified independent entity.* The results of the independent external review must be made public.

The OMPP has developed standards for evaluating the quality of all managed care entities. The standards set are expected to meet or exceed those to be adopted by the CMS.

Scope of MCO Monitoring Contractor Activities

The monitoring contractor assists the OMPP in evaluating the effectiveness and efficiency of the Hoosier Healthwise Managed Care program, its participating MCOs. The monitoring contractor evaluates the readiness of newly-contracted MCOs to participate in the Hoosier Healthwise program and assesses compliance of all MCOs with federal and state regulations and contract provisions. The monitoring contractor also compares MCO policies, procedures, and performance against nationally-established standards such as a *Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States* (CMS) and *Medicaid HEDIS National Committee for Quality Assurance (NCQA)* as well as Indiana's state-specific performance standards. The monitoring contractor works with the OMPP, other OMPP contractors, and the MCOs to provide the OMPP with analysis, findings, and recommendations for quality improvement.

The OMPP identified the following six components of the scope of activities for the monitoring contractor:

- Readiness reviews of all new MCO contracts
- Quality indicators and studies (HEDIS or State-designed)
- Quarterly report analysis
- Shadow claims validation
- Annual external quality review
- Other activities assigned by the OMPP

In general, the OMPP provides guidance to the contractor by reviewing analyses, recommendations, findings, and so forth, and by providing necessary input regarding the components of the scope of activities. The OMPP also determines the frequency, content, and format of all deliverables.

Readiness Reviews

To assist the OMPP in monitoring quality of care, the contractor is responsible for conducting a readiness review of MCOs that contract with the OMPP to determine if the organization is prepared to operate and accept enrollment.

The monitoring contractor verifies that certain program components are present and that a plan is in place to implement the requirements, before the MCO is allowed to deliver services to the Hoosier Healthwise population. These program components include, but are not limited to, the following:

- Network development (access or availability of services)
- Administration and organizational structure
- Utilization and financial information
- Education and outreach for members and providers
- Management information systems, including claims processing and shadow claims (encounter claim-level data) submission capabilities
- Member and provider services, including complaint and grievances processes
- Quality management and improvement, including internal quality assurance plans

Readiness reviews typically begin at least six to eight weeks before the date a new health plan intends to serve Hoosier Healthwise enrollees.

If the contractor reports that the MCO is not meeting the readiness review requirements, the OMPP requires the MCO to develop a corrective action plan that includes a schedule for activities for the corrective action. If the MCO does not implement the requirements within the time indicated in the corrective action plan, sanctions can be issued by the OMPP, or the contract can be terminated.

Performance Reporting

The State places great emphasis on the delivery of quality health care to Hoosier Healthwise members. Performance monitoring and data analysis are critical components in assessing how well the MCO is maintaining and improving the quality of care delivered in the Hoosier Healthwise program. The State uses various performance targets, industry standards, national benchmarks, and Hoosier Healthwise-specific standards in monitoring the MCO's performance and clinical outcomes. The MCO must submit performance data specific to the Hoosier Healthwise program unless otherwise specified by the OMPP. The State publishes the Hoosier Healthwise program's performance and recognizes the MCO when it exceeds these performance indicators.

The MCO must comply with all reporting requirements and must submit the requested data completely and accurately within the requested timeframes and in the formats identified by the OMPP. The MCO must have policies, procedures, and mechanisms in place to ensure its financial and non-financial performance data that is submitted to the OMPP and the monitoring contractor is accurate and a true reflection of the MCO's operational efficiency. The MCO must submit its performance data and reporting under the signatures of its financial officer and executive leadership (such as, President, Chief Executive Office, Executive Director) certifying the accuracy, truthfulness and completeness of

the MCO's data. The *MCO Reporting Manual* details the reporting requirements that are highlighted below.

The OMPP reserves the right to audit the MCO's self-reported data and change reporting requirements at any time with reasonable notice. The OMPP may require corrective actions or assess liquidated damages for MCO non-compliance with these and other subsequent reporting requirements and performance standards.

Management Information Systems Reports

These reports assist the OMPP in monitoring the MCO's performance, data collection, and maintenance of network information systems that the MCO administers to ensure members access and utilization through the MCO's providers. The MCO must submit claims and shadow claims processing and adjudication data. The MCO must also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing and shadow claim submission. Examples of possible data and reports are as follows:

- Shadow Claims and Encounter Data Submissions (Monthly)
- Shadow Claims Workplans (At least annually or as determined by the OMPP)
- Adjudicated Claims Inventory Summary (Quarterly)
- Top 10 Claims Denial Reasons (Quarterly)
- Claims Processing Summary (Quarterly)

Member Service Reports

Member service reports identify the methods the MCO uses to communicate to members about preventive health care and program services and monitors member satisfaction. The following are examples of member service reports:

- Member Helpline Performance Report (Monthly or as determined by OMPP)
- Member Grievances Report (Monthly)
- Member Appeal Report (Monthly)
- Medicaid Hearing Appeals (As determined by the OMPP)
- Executive Summary of CAHPS Survey Results (Annually)

Network Development Reports

Network development reports assist the OMPP in monitoring the MCO's network composition by specialty and county to assess member access and network capacity. The MCO must identify current enrollment, gaps in network services and the corrective actions that the MCO is taking to resolve any potential problems relating to network access and capacity. Examples of possible network development reports include, but are not limited to the following:

- Network Access Directory (Monthly, or as requested by the enrollment broker)
- Network Geographic Access Report and Map (Annually)
- Provider Network Enrollment Report (Quarterly)
- Provider Network Disenrollment Reasons (Quarterly)

- Provider Credentialing Statistics (Quarterly)
- 24-Hour Availability Audit (Annually)
- Subcontractor Compliance Summary Report (Annually)

Provider Service Reports

Provider service reports assist the OMPP in monitoring the methods the MCO uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program. Examples of possible reports include the following:

- Provider Helpline Performance Report
- Executive Summary of Provider Survey Results
- Informal Provider Claims Disputes (Quarterly)
- Formal Provider Claims Disputes (Quarterly)
- Binding Arbitration (As determined by OMPP)

Quality Management Reports

Quality management reports review the ongoing or future methods and processes the MCO uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality, and utilization of program services by its members and providers. These reports assist the OMPP in monitoring the MCO's quality management and improvement activities. Examples of possible reports include the following:

- Quality Management and Improvement Program Plan (Annually)
- Quality Management and Improvement Program Summary Report (Annually)
- Sentinel Events (Annually, Optional)
- Obesity Report (Quarterly, Optional)
- Summary of Provider Profiling Activity (Annually)
- Summary of Findings From Internal Quality Studies (Quarterly)
- Quality Management Committee Meeting Minutes (Quarterly)
- Summary of Findings from Quality Management and Improvement Activities (Quarterly)
- DUR Board Reporting (Quarterly)
- HEDIS Baseline Assessment Tool (Annually)
- HEDIS Data Submission Tool (Annually)
- HEDIS Auditor Report (Annually)
- CAHPS Survey Data (Annually)
- Program Integrity Workplan (Annually)
- Program Integrity Activities Summary (Annually)
- Disease Management Summary Report

Financial Reporting

The purpose of MCO financial reporting is to provide sufficient data and related financial information for the OMPP to accurately monitor the financial performance of the contracted MCO. The OMPP uses the information to take appropriate action in the best interests of the State and IHCP members.

Federal regulations require that the risk-based MCO maintain a fiscally solvent operation. The risk-based MCO must also give the OMPP the right to evaluate the ability of the risk-based MCO to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the contract. The Indiana Department of Insurance (IDOI) maintains primary responsibility for regulating MCO solvency by requiring a minimum net worth and a set reserve amount.

Each MCO is required to submit information detailing its financial standing and stability in a quarterly report. The MCO must deliver to the OMPP and monitoring contractor copies of the quarterly and annual financial reports filed with the IDOI. Refer to the *MCO Reporting Manual* for more information.

Financial reports must be specific to the MCO's Hoosier Healthwise population (for example, financial records for the Hoosier Healthwise services must be maintained in a separate book of business). These reports must be submitted in standard formats, as required.

Utilization and Financial Reports

Utilization and financial reports assist the OMPP in monitoring the MCO's utilization and financial trends to assess its stability and continued ability to offer health care services to its members. If the MCO does not meet the financial reporting requirements, the State notifies the MCO of the non-compliance and designates a period of time, not less than 10 calendar days, during which the MCO must provide a written response to the notification. Examples of possible reports include the following:

- Capitation Rate Calculation Sheet (Quarterly)
- Maternity Capitation Rate Calculation Sheet (Quarterly)
- Service Utilization - Physical Health (Quarterly)
- Service Utilization - Behavioral Health (Quarterly)
- Financial Stability Indicators (Quarterly)
- IDOI Filing (Quarterly, Annually)
- Reimbursement for FQHC and RHC Services (Quarterly)
- Physician Incentive Plan Disclosure (Annually, At OMPP's Request)
- Insurance Premium Notice (Annually)
- Medical Necessity Determination Denials and Appeals (Quarterly)
- Third-Party Liability Collections (Quarterly)
- Cost Avoidance (Annually)

Performance Monitoring and Incentives

The primary source of data the State uses in its monitoring efforts is data submitted by the MCO, which comes to the State in various formats and at different times. The data may be transmitted as an aggregate report, specific data elements, or via shadow claims. The OMPP and its monitoring contractor review the MCO's data and compare the results to established performance targets, such as, Hoosier Healthwise standards, national benchmarks, or industry standards. The *MCO Reporting Manual* provides information on performance reporting and targets.

The OMPP may award non-financial incentives to the MCO whose performance is consistently above the targets for the majority of the measures listed below. The OMPP also reserves the right to assess liquidated damages or apply other remedies for failure to meet the minimum requirements listed below.

Performance Targets, Standards, and Benchmarks

The following are the performance indicators and the performance target for each measure. The OMPP reserves the right to identify additional performance indicators and targets.

- The MCO must maintain its average monthly telephone service for member services helpline efficiency at 95 percent of calls received being answered by a live voice within 30 seconds and service rates (such as., opposite of abandonment rate) not less than 95 percent.
- On a quarterly basis, the ratio of MCO members to PMPs is no greater than an average of 250 members to one PMP across all mandatory RBMC counties.
- Ninety-eight percent of the MCO's members must have pharmacy access within 30 miles or 30 minutes of the member's residence.
- For mandatory RBMC counties, at least two specialty providers of each specialty type will be accessible to 90 percent of all the MCO's members within 60 miles or 60 minutes of the member's residence ZIP™ code.
- All clean claims submitted electronically must be adjudicated within 21 calendar days of receipt.
- All clean claims submitted on paper must be adjudicated within 30 calendar days of receipt.
- All MCO adjudicated claims must be submitted as shadow claims within 30 days of adjudication.
- All member grievances must be resolved within 20 calendar days of receipt.
- All children must receive a blood lead screening and testing in accordance with EPSDT and Centers for Disease Control (CDC) guidelines.
- All children must receive EPSDT screening visits in accordance with EPSDT guidelines.
- On a quarterly basis, the year-to-date average medical cost ratio is between 83 and 88 percent of revenue.
- On a quarterly basis, the year-to-date average administrative cost ratio is no greater than 15 percent of revenue.
- On an annual basis, operating profit margin is not be greater than 10 percent.
- On a quarterly basis, current ratio (assets to liability) is greater than or equal to one.
- On a quarterly basis, the number of days cash on hand is not be less than 25 business days.
- On a quarterly basis, days in unpaid claims is not be greater than 65 business days.
- On a quarterly basis, days in claims receivables is not be greater than 30 business days.

- On a quarterly basis, equity (net worth) is maintained at or above $50 per member.

Reporting Requirements

Reporting provides regular communication and information about the status of the Hoosier Healthwise program. Reports also help identify issues and trends that can lead to development of Hoosier Healthwise program improvements. The MCO must meet the reporting requirements described in the following subsections.

Quarterly Reports

MCOs must submit quarterly reports, due on the last day of the month following the reporting quarter, to the OMPP and the monitoring contractor. The quarterly reports comprise seven sections outlined in the following text. The *Quarterly Reporting* manual provides additional details.

Network Development

Purpose – To identify the services provided within the network and assess how well the MCO is addressing the needs of the program related to access and capacity. The MCO must identify current enrollment, gaps in enrollment, and the steps to take to resolve potential problems related to network development.

Management Information Systems

Purpose – To identify the collection of data and maintenance of network information systems for MCO management of services accessed by members and providers. The MCO must submit claims processing and shadow claims processing adjudication data. The MCO must also identify specific cases and trends to prevent and respond to potential problems related to timely and appropriate claims processing.

Quality Improvement

Purpose – To state the ongoing or future methods and processes used to identify program and clinical improvements made to enhance appropriate access, quality, and use of program services by members and providers.

Member Education and Outreach

Purpose – To provide a progress update of the annual plan to communicate to members about preventive health care and program services.

Provider Education and Outreach

Purpose – To provide a progress update of the annual plan to communicate to providers about clinical, technical, and quality improvement issues related to the program.

Utilization and Financial Reporting

Purpose – To identify utilization and financial trends. Reports include:

- Capitation rate calculation sheets (CRCS)

- Medicaid, Medicare, and commercial population enrollment
- Report of financial stability indicators
- Stop-loss or reinsurance information
- Financial statements required by Department of Insurance

Other Reporting

Purpose – To state program-related issues that may not change quarterly, but are necessary for program monitoring including, but not limited to the following:

- Annual summary of activities
- Annual work plan of future activities for network development, member and provider education and outreach
- Physician Incentive Plan (PIP), which includes PIP disclosure and member satisfaction and member disenrollment survey results.
- Shadow claim submission schedule

Quarterly Report Timeliness Requirements

MCOs must refer to the *Quarterly Reporting Manual* for submission dates. MCOs anticipating any delay in submitting a quarterly report to the OMPP and the monitoring contractor must contact the OMPP by the reporting date to obtain an approved extension.

The OMPP and the monitoring contractor review the MCO quarterly reports and send review comments and questions back to the MCO. MCOs must respond to requests made by the OMPP or the monitoring contractor in relation to quarterly report reviews within the time frame identified in the quarterly report review or by the next quarterly report submission date, whichever is the earliest.

If the MCO does not comply with the submission of the quality improvement reporting requirements or fails to address review requests, the OMPP notifies the MCO of the noncompliance and designates a period of not less than 10 days in which the MCO must provide a written response to the notification. Otherwise, the OMPP reserves the right to assess liquidated damages.

Additional Reports

The MCO must also submit the following reports to the OMPP:

- Quality indicators, which include, but are not limited to the following:
  - 24-hour access audit
  - Appointment access audit
  - Member satisfaction surveys
  - Provider satisfaction surveys
  - QIC monthly data grid
- Focused patterns of care studies and HEDIS measures
- Reports to the Drug Utilization Review (DUR) Board
- Other ongoing reports as identified by the OMPP
- Ad hoc reports as determined by the OMPP

Failure to Perform and Non-compliance Remedies

Non-compliance Remedies

It is the State's primary goal to ensure that the MCO is delivering quality care to members. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the MCO accountable for being in compliance with contract terms. The OMPP accomplishes this by working collaboratively with the MCO to maintain and improve programs, and not to impair health plan stability.

If an MCO fails to meet performance requirements or reporting standards, the State provides the MCO with a written notice of non-compliance and may require any of the corrective actions discussed in the *Corrective Action* section. The State provides written notice of non-compliance to the MCO within 60 calendar days of the State's discovery of such non-compliance.

If the OMPP elects not to exercise a liquidated damage or corrective action clause this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that may be retroactively assessed.

Corrective Actions

In accordance with *42 CFR 438, Subpart I*, the OMPP may require corrective action(s) when the MCO has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity, and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- *Written Warning:* The OMPP may issue a written warning and solicit response regarding MCO's corrective action.
- *Formal Corrective Action Plan:* The OMPP may require the MCO to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the MCO's chief executive and must be approved by the OMPP. If the corrective action plan is not acceptable, the OMPP may provide suggestions and direction to bring the MCO into compliance.
- *Withholding Full or Partial Capitation Payments:* The OMPP may suspend capitation payments for the following month or subsequent months when the State determines that the MCO is non-compliant. The MCO must be given written notice 10 business days prior to the suspension of capitation payments and specific reasons for non-compliance that result in suspension of payments. The State may continue to suspend all capitation payments until non-compliance issues are corrected.
- *Suspending Enrollment:* The OMPP may suspend the MCO's right to enroll new participants by disallowing self-selection by members and/or auto-assignment of members to the MCO. The State may suspend enrollment for the entire MCO or may selectively suspend enrollment for a region, county, or a specific provider. The State notifies the MCO in writing of its intent to suspend new enrollment at least 10 business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State bases the duration of the suspension upon the nature and severity of the default and the MCO's ability to cure the default.
- *Assigning the MCO's Membership and Responsibilities to Another MCO:* The State may assign the MCO's membership and responsibilities to one or more other MCOs who also provide services to the Hoosier Healthwise population, subject to consent by the MCO that would gain that responsibility. The State must notify the MCO in writing of its intent to transfer members and

responsibility for those members to another MCO at least 10 business days prior to transferring any members.

- *Appointing Temporary Management of the MCO:* The State may assume management of the MCO or may assign temporary management of the MCO to the State's agent, if at any time the State determines that the MCO can no longer effectively manage the MCO and provide services to members.
- *Contract Termination:* The State reserves the right to terminate the contract, in whole or in part, due to the failure of the MCO to comply with any term or condition of this contract, or failure to take corrective action as required by the OMPP to comply with the terms of this contract. The State must provide 30 calendar days written notice and must set forth the grounds for termination.

Liquidated Damages

In the event that the MCO fails to meet performance requirements or reporting standards it is agreed that damages shall be sustained by the State and the MCO shall pay to the State its actual or liquidated damages according to the following subsections and subject to the limitations provided in *Section 1932(e) of the Balanced Budget Act of 1997*.

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the MCO will pay the State for such failures according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

The OMPP may assess liquidated damages resulting from failure of the MCO to provide the requested services depending on the nature, severity, and duration of the deficiency. In most cases, liquidated damages will be assessed based on the schedules contained in this policy and procedure manual. However, the assessment of liquidated damages is at the discretion of the OMPP. Should the OMPP choose not to assess liquidated damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess liquidated damages at any point in the future. The OMPP may assess liquidated damages for any of the areas of non-compliance listed in the following section of this policy or for any other areas of non-compliance, at the discretion of the OMPP.

Non-compliance with General Contract Provisions

The objective of this requirement is to provide the State with an administrative procedure to address issues where the MCO is non-compliant with the contract. Through routine monitoring, the State may identify contract non-compliance issues resulting from non-performance. If this occurs, the State will notify the MCO in writing of the nature of the non-performance issue. The State will establish a reasonable period of time, not less than 10 business days, during which the MCO must provide a written response to the notification. If the MCO does not correct the non-performance issue within the specified time, the State may enforce any of the remedies listed in this policy.

Non-compliance with Shadow Claims Data Submission

The MCO must comply with the shadow claims submission standards. The State may assess liquidated damages on the following elements of shadow claims submissions:

- *Timeliness of the MCO's Shadow Claims Submission to the State's Fiscal Agent:* If the MCO fails to submit all claim types per month, the MCO must pay liquidated damages of $2,000 for each claim type not submitted during that month.

In addition, the State's fiscal agent must conduct a monthly review of the MCO's rate of compliance with the established schedule for submitting shadow claims within 90, 180, and 365-day increments. The State may assess liquidated damages in the amount of $200 per claim type, per percentage point of non-compliance. For example, if the MCO should have submitted 95 percent of UB-92 claims within 180 calendar days but submitted only 93 percent, the State may assess liquidated damages of $400 (for example, two percentage points x $200 per percentage point = $400). The State may assess damages for any or all of the three time frames.

- *Compliance with Pre-Cycle Edits:* The MCO's shadow claim submission must pass pre-cycle edits. For each batch submitted, the MCO must reach a 98 percent compliance rate. The State assesses liquidated damages based on an overall average of calendar monthly submissions. For compliance levels lower than 98 percent, the State assesses the following liquidated damages:

Table 9.1 – Liquidated Damages

Percent of Claims Accepted	Liquidated Damages Amount
93.0 - 97.9	$200
88.0 - 92.9	$600
83.0 - 87.9	$1,000
78.0 - 82.9	$1,400
76.0 - 77.9	$1,800
0 - 75.9	$2,000

In addition, if the MCO's non-compliance continues beyond one month, the State may multiply the amount of the liquidated damages by the number of months of continuing non-compliance. For example, if the MCO's rate of acceptance of shadow claims is below 75 percent for three consecutive months, the State may assess liquidated damages for the third month of non-compliance in the amount of $6,000, or three times the monthly damage amount of $2,000.

- *Compliance with Back-end Edits:* For each claim type submitted, 90 percent of those claims must pass the fiscal agent's back-end edits with a paid status in a calendar month. For compliance levels below 90 percent, the OMPP may require corrective action plans, or may assess liquidated damages based on the schedule below:

Table 9.2 – Liquidated Damages

Percent of Details Accepted	Liquidated Damages Amount
85.0-89.9	$100
80.0-84.9	$300
75.0-79.9	$500
70.0-74.9	$700
65.0-69.9	$900
00.0-64.9	$1,000

In addition, if the MCO's non-compliance continues beyond one month, the State may multiply the amount of the liquidated damages by the number of months of continuing non-compliance. For example, if the MCO's rate of acceptance of shadow claims is below 65 percent for three consecutive months, the State may assess liquidated damages for the third month of non-compliance in the amount of $3,000, or three times the monthly damage amount of $1,000.

Non-compliance with Reporting Requirements

The *MCO Reporting Manual* details the required formats, templates, and submission instructions for the reports listed in this policy. The State may assess liquidated damages of $200 for each business day past the date due when reports are not delivered complete, on time, and in the correct reporting formats, or submitted incorrectly.

If the MCO's non-compliance to the reporting requirements impacts the State's ability to monitor the MCO's solvency, and the MCO's financial position requires the State to transfer members to another health plan, the State will require the MCO to pay the difference between the capitation rates that would have been paid to the MCO and the actual rates being paid to the replacement health plan as a result of member transfer. In addition, the MCO must pay any costs the State incurs to accomplish the transfer of members. Further, OMPP may withhold all capitation payments or require corrective action until satisfactory financial data is provided.

Section 10: Management Information Systems

Overview

The Managed Care Organization (MCO) must have a Management Information System (MIS) sufficient to support the Hoosier Healthwise program requirements. The MCO must have a plan for accessing and storing data files and records in a manner that is in keeping with Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements, transmission, and maintenance of confidential medical data, including:

- Administrative procedures
- Physical safeguards
- Technical safeguards

The MCO must develop, implement, and maintain an MIS with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis tasks described in this policy. The MCO must have a mechanism(s) in place to link data into a relational database reflecting all functional area's data integration. The MCO must have policies and procedures to describe and support the MIS back-up plans, as well as a disaster recovery plan. The MCO must have policies and procedures addressing auditing and monitoring subcontractors' data and performance. The MCO must integrate subcontractors' financial and performance data (as appropriate) into the MCO's MIS to accurately and completely report MCO performance and confirm contract compliance.

The MCO must make all collected information available to the Office of Medicaid Policy and Planning (OMPP) and, upon request, to the Centers for Medicare and Medicaid Services (CMS). In accordance with *42 CFR 438, subpart H*, the MCO must submit all data under the signatures of its Financial Officer and Executive leadership (for example, President, Chief Executive Office, Executive Director) certifying the accuracy, truthfulness, and completeness of the MCO's data.

Disaster Recovery Plans

The MCO must protect against hardware, software, and human error. The MCO must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery. The MCO must maintain full and complete back-up copies of data and software, and must proficiently back on tape or optical disk and store its data in an approved off-site location. The MCO must maintain or otherwise arrange for an alternate site for its system operations in the event of a catastrophe or other serious disaster. (For purposes of this policy, *disaster* means an occurrence of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the MCO's or its subcontracting entities claims processing system or affects the performance, functionality, efficiency, accessibility, reliability, or security of the system.) The MCO must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the MCO will jointly determine when unscheduled system downtime will be elevated to a disaster status. Disasters may include natural disasters, human error, computer virus, or malfunctioning hardware or electrical supply.

The MCO's responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.

- Establishing and maintaining, in an electronic format, a weekly back-up that is adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation.
- Establishing and maintaining, in an electronic format, a daily back-up that is adequate and secure for all computer software and operating programs databases tables; files; and systems, operations, and user documentation.
- Demonstrating an ability to meet back-up requirements by submitting and maintaining a Disaster Recovery Plan that addresses:
  - Checkpoint and restart capabilities
  - Retention and storage of back-up files and software
  - Hardware back-up for the servers
  - Hardware back-up for data entry equipment
  - Network back-up for telecommunications
- In the event of a catastrophic or natural disaster, resuming normal business functions at the earliest possible time, not to exceed 30 calendar days. If deemed appropriate by the State, coordinating with the State's fiscal agent to restore the processing of claims by Indiana*AIM* if the claims processing capacity cannot be restored within the MCO's system.
- In the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, resuming normal business functioning at the earliest possible time, not to exceed 10 calendar days.
- Developing coordination methods for required system operational activities with other the MCO, including back-ups of information sent or accepted.
- Providing the State with regularly updated business resumption documents, such as:
  - Disaster recovery plans
  - Business continuity and contingency plans
  - Facility plans
  - Other related documents as identified by the State

Member Enrollment Data Exchange (834)

The MCO is responsible for verifying member eligibility and the receipt of capitation payments for each eligible member. The MCO must reconcile its eligibility and capitation records monthly. If the MCO discovers a discrepancy in eligibility or capitation information, the MCO must notify OMPP and the State's fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after OMPP delivers the eligibility records. The MCO must return any capitation overpayments to OMPP. If the MCO receives either enrollment information or capitation for a member, the MCO is financially responsible for the member.

The MCO is required to accept enrollment data in electronic format. The *Companion Guide – 834 MCO Benefit Enrollment and Maintenance Transaction* details the enrollment data exchange. The MCO is responsible for loading the eligibility information into its claims system within five calendar days of receipt. The State's fiscal agent produces the enrollment rosters semi-monthly (See *Appendix S: EDS MCO Jobs Schedule* for dates this job runs) changes in enrollment may occur during the interim period between the production of the roster and the effective date. For example, a member who is auto-assigned to an MCO on the 20th day of the month with an effective date on the first day of the following month appears on the MCO enrollment roster produced on the 26th of the month. If that member loses eligibility in the Hoosier Healthwise Program, and that loss is reported between the 26th day and the end of the month, this deletion is included on the second enrollment roster of the month. Because the member lost eligibility prior to the effective date in the MCO network, he or she is

reported as a deleted member on the next enrollment roster. If the MCO has questions about the 834 transaction they can contact the fiscal agent's managed care director.

Provider Network Data

Each quarter, by the last day of the month following the reporting quarter, the MCO must notify the OMPP or its agent of all providers, including specialty and ancillary providers, enrolled in its network.

Claims Processing

The MCO must have policies and procedures to audit and monitor provider encounter claim submissions to validate accuracy, completeness, and timeliness of claims information to the services rendered to the MCO's Hoosier Healthwise members. The MCO must have policies and procedures regarding claims submissions and processing that integrate with and support the internal quality management and improvement plan.

Claims Processing Capability

The MCO must demonstrate and maintain the capability to control, process, and pay provider claims for services rendered to the MCO's members. The MCO must have the capability to collect and generate service-specific procedure and diagnosis data on a per member basis, to price specific procedures or encounters (depending on the agreement between the provider and the MCO), and to maintain detailed records of remittances to providers.

The MCO must develop internal criteria for determining an acceptable level of claims adjudication accuracy and encounter submission accuracy. The MCO must develop policies and procedures to monitor claims adjudication accuracy against its internal standards. The MCO must submit its internal standards for determining an acceptable level of claims adjudication accuracy and its policies and procedures for monitoring its claims adjudication accuracy against the MCO's internal criteria to OMPP for review and approval. The State recommends that the MCO establish its internal claims processing and financial accuracy standards to be no less than 97 percent claims processing accuracy and 99 percent financial accuracy.

Each year as part of the MCO's annual *Quality Management and Improvement Program Plan Summary Report*, the MCO must detail its claims adjudication accuracy monitoring activities, corrective actions that were implemented as a result of the monitoring and submit any changes to its internal standards. Additionally, in the annual *Quality Management and Improvement Program Plan Summary Report*, the MCO must submit descriptions of all incentives and penalties it imposed on providers to encourage claims and encounter submission accuracy.

Compliance with State and Federal Claims Processing Regulations

The MCO must have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The MCO's system must process all claim types such as professional, institutional, and pharmacy claims. The MCO must comply with the claims processing standards and confidentiality standards under *IC 12-15-13-1.6* and *IC 12-15-13-1.7*, and any applicable federal regulations. The MCO must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers.

Claims Payment Timelines

The MCO must pay or deny electronically-filed clean claims within 21 calendar days of receipt. (As set forth in *IC 12-15-13.0.6*, a *clean claim* is one in which all information required for processing the claim is on the claim form.) The MCO must pay or deny clean paper claims within 30 calendar days of receipt. If the MCO fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the MCO must also pay the provider interest as required under *IC 12-15-13-1.7(d)*. The MCO must pay interest on all clean claims paid late (for example, in- or out-of-network claims) for which the MCO is responsible, unless the MCO and provider have made alternate written payment arrangements. The OMPP reserves the right to perform a random sample audit of all claims, and expects the audited MCO to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

Subcontracting Claims Processing Functions

If the MCO subcontracts all or some of the claims processing functions to a State-approved subcontractor, the MCO must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers. The MCO must demonstrate that use of the subcontractor will not result in confusion to the provider community about where to submit claims for consideration of payment. For example, the MCO may elect to establish one central post office box for submission of all out-of-network and self-referral provider claims. If different subcontracting organizations are responsible for processing those claims, the MCO is responsible to ensure that the claims are forwarded to the appropriate processing entity. Use of a claims processing subcontractor will not lengthen the timeliness standards outlined in this policy. In this example, date of receipt will be defined as the date the claim is received at the post office box.

Shadow Claims Reporting

Shadow claims are reports of individual patient encounters with an MCO's health care network. The MCO must submit a shadow claim to the State's fiscal agent for every service rendered to an enrollee for which the MCO either paid or denied reimbursement. These claims, which have been reimbursed in capitation by the OMPP to the MCO, contain fee-for-service equivalent detail about procedures, diagnoses, places of service, billed amounts, and rendering or billing providers. With some minor variations unique to shadow claims, the MCOs report shadow claims using the IHCP standard provider billing requirements.

Shadow claims update a member's detailed claim history and reflect all benefit limitations applicable to fee-for-service programs as defined in the IAC. It is critical that service utilization for the Hoosier Healthwise program's MCO enrollees be documented in Indiana*AIM* claim history. Such documentation provides for appropriate claim adjudication if a member maintains eligibility in a fee-for-service program after disenrollment from a risk-based program.

The accuracy of MCO-submitted shadow claims is essential to the integrity of the claim system that collects data for IHCP's traditional programs, including Hoosier Healthwise. The OMPP uses shadow claims to collect member-specific claim data for utilization analysis, quality control, program cost analysis, and future capitation rate adjustments.

After successful completion of the MCO contract, MCOs are provided with the *EDS Electronic Claims Submission Manual* and the *EDS Claim Resolutions Manual.* These manuals detail specific claim submission requirements and are referred to throughout this section about shadow claims. *Appendix L: Shadow Claims Processing Terminology* gives terminology specific to shadow claims.

Detailed claims data must reflect all MCO-covered services provided examples are the following:

- Hospital services
- Surgical services
- Physicians' services, including EPSDT screenings
- Laboratory services
- Radiology services
- Durable medical equipment and medical supplies
- Transportation services
- Pharmacy services
- Ancillary services, including home health care
- Additional services provided through wellness programs or other preventive services provided to the Hoosier Healthwise population

The MCO must have policies, procedures, and mechanisms in place to support the shadow claims reporting process. The MCO Technical Meeting provides a forum for MCO technical support staff to ask questions related to data exchange issues, including shadow claims transmission and reporting issues. The MCO must report any problems it is experiencing with shadow claims submissions and reporting at this monthly meeting. The *Electronic Claim Capture Shadow Claim Submission Technical Reference Manual* and the *Companion Guides-837 Institutional and Professional Claim and Encounter Transaction* provide detailed instructions to guide the MCO in reporting shadow claims data.

Shadow Claims Submission

The MCO must submit institutional and professional shadow claims data in an electronic format that adheres to the data specifications in the Companion Guide-837 Institutional and Professional Claim and Encounter Transaction and any other State or Federally-mandated electronic claims submission standards. The MCO must submit pharmacy shadow claims data in an electronic format that adheres to NCPDP data specifications. MCOs can submit these files to IHCP quickly, easily, and securely with File Exchange over encrypted connections using the FTP over SSL (FTPS), FTP over SSH (SFTP), and HTTP over SSL (HTTPS) protocols.

More information about submitting electronic files to the IHCP can be found in the Electronic Data Interchange Communications Companion Guide (located at www.indianamedicaid.com/ihcp/TradingPartner/companionguides/comm.pdf).

The MCO must submit at least one batch of shadow claims for institutional, professional, and pharmacy claims each month. The OMPP accepts more than one submission, but uses an overall average of calendar month submissions to assess compliance with the shadow claims submission requirements set forth in Section 10. The State may require the MCO to submit a corrective action plan or may assess liquidated damages for failure to comply with the shadow claims submission requirements.

Claim Elements Unique to Shadow Claims

Shadow claims mirror fee-for-service claims, ensuring the continuity of data collected. Additional claim filing elements, unique to shadow claims processing and submission, are described as follows:

- The MCO Identification Number and Region Identifier is assigned to an MCO on enrollment in Hoosier Healthwise. This is a nine-digit number with a 10th digit alphabetic character denoting the geographic region of the state where the MCO is contracted to provide services. The MCO ID and region identifier is required on all shadow claims submissions in the fields designated in the electronic shadow claims field elements available in the MCO orientation package described in *Section 8: MCO Enrollment and Network Development* of this manual.
- Value codes and value code amounts are required on UB-92 claims to designate the MCO's reimbursement methodology and actual amount paid on the claim. Omission or incorrect data in the value code fields causes the claim to adjudicate with a denied status for one of the following reasons:
  - Value code missing
  - Value code amount missing
  - Value code amount invalid
  - Value codes, specific to shadow claims, and their corresponding claim types are:
  - Z1 – Inpatient DRG
  - Z2 – Level of Care
  - Z3 – Inpatient Per Diem
  - Z4 – Outpatient
  - Z5 – Nursing Home/Long Term Care Facility
  - Z6 – Home Health Care
  - Z7 – Other

Additional claim elements that need to be included for shadow claims can be found in the 837P and 837I companion guides.

Delivery Capitation Payments from Shadow Claims

While most shadow claims are used for data reporting and utilization purposes, claims that report obstetric deliveries serve the dual purpose of data reporting and capitation payment. Delivery capitation is paid per occurrence and is generated from a paid UB-92 shadow claim reporting the birth of a child to a MCO-enrolled member. The following Inpatient hospital diagnosis-related groupings (DRGs), when adjudicated with a paid status, generate the additional delivery capitation payment:

- 370 – cesarean section with CC
- 371 – cesarean section without CC
- 372 – vaginal delivery with complicating diagnoses
- 373 – vaginal delivery without complicating diagnoses
- 374 – vaginal delivery after sterilization and/or D and C
- 375 – vaginal delivery with OR procedure except sterilization and/or D and C
- 650 – high risk cesarean section with CC
- 651 – high risk cesarean section without CC
- 652 – high risk vaginal delivery with sterilization and/or D and C

The institutional-based delivery capitation payment is generated under the mother's RID and MCO on the date of admission versus the date of delivery.

The *IHCP Provider Manual* gives detailed billing instructions for prenatal care, delivery, and postpartum care claims. While it is the UB-92 delivery claim that generates an additional capitation

payment, it is critical for reporting, utilization, and monitoring functions that all shadow claims for maternity care are submitted.

Effective November 1, 2004, the inpatient/outpatient hospital reimbursement rule published in *405 IAC 1-10.5-3(z)* was revised to require providers to bill any inpatient stay that is less than 24 hours as an outpatient service. As a result of these changes, when a member has an inpatient delivery stay less than 24 hours, the inpatient stay must be billed as an outpatient service. Because the delivery capitation process only considers inpatient claims for capitation payments an MCO would not receive a capitation payment for the delivery.

When an MCO becomes aware of a claim for an inpatient delivery stay that is less than 24 hours, the MCO must inform the fiscal agent of the inpatient stay. The MCO must notify the fiscal agent by downloading and completing the Delivery Capitation Request form from the IHCP Web site (http://www.indianamedicaid.com/ihcp/HoosierHealthwise/content/mco%5Fqa/).

The completed form must be sent by e-mail to the fiscal agent at INXIXManagedCare@eds.com. Then the fiscal agent sends an e-mail to the MCO confirming that the completed form has been received.

When the MCO notifies the fiscal agent, the fiscal agent must confirm the following:

1. An outpatient delivery encounter claim has adjudicated as paid through Indiana*AIM*.
2. There are no paid inpatient delivery encounter claims in Indiana*AIM* history for the member on the reported date of service.
3. There are no other delivery capitation payments made on behalf of the member within the last nine months.

After the fiscal agent has a positive confirmation of the aforementioned situations, the fiscal agent must execute the manual process to ensure the MCO receives a delivery capitation payment for the member.

The fiscal agent ensures that the delivery capitation payment is issued during the capitation cycle following the verification process.

Shadow Claims Edits and Audits

Shadow claims are subjected to appropriate system edits to ensure data validity. These edits fall into the following two broad categories:

- Electronic claim capture (ECC) precycle edits
- Claim resolution edits and audits (also referred to as back-end edits)

Precycle editing establishes the presence and validity of certain critical data elements prior to the claim's acceptance into Indiana*AIM*. For example, to pass the precycle edit, the RID field must contain a valid combination of numeric characters recognized by the system. The precycle editing process does not attempt to link the number to a specific member's eligibility or other information. The ECC precycle edits for shadow claims are identical to those in fee-for-service electronic claim submission (ECS) claims except for the addition of two edits created for shadow claims: MCO ID MISSING and MCO ID INVALID. The precycle edits are described in the EDI Reports and Acknowledgements document located at http://www.indianamedicaid.com/ihcp/TradingPartner/tp_companion_guides.asp and the *ASC X12N 837 Institutional and Professional Implentation Guides* located at http://www.wpc-edi.com/content/view/533/377/.

Claim resolution editing and auditing validates information specific to a particular enrollee's IHCP program eligibility, subprogram affiliation, and claim history. These edits and audits are designed to support benefit limits and conditions of payment in state and federal program requirements and are described fully in *the EDS Claim Resolutions Manual*. For example, a claim with a RID number accepted in the system during precycle editing, may be denied during claim resolution editing if the member was ineligible for benefits on the date of service, or if the member name or RID number on the claim did not match the name or RID number on file in Indiana*AIM*.

For each claim type submitted, 90 percent of those claims submitted in a calendar month must pass the fiscal agent's back-end edits and have a resulting paid status assigned by the fiscal agent. The OMPP recognizes that certain claims are assigned a denied status appropriately, and as a result, the MCO may not be able to attain a 100 percent compliance rate with back-end edits at all times. However, the MCO must correct and resubmit the remaining 10 percent with a goal of achieving as close to 100 percent paid status as possible. Each resubmission is included in the overall average of calendar month submissions for the calculation of paid and denied status. The OMPP may require corrective action plans, assess liquidated damages by claim type for submissions that fall below the 90 percent compliance standard, or initiate other corrective action for the MCO's failure to comply.

In the IHCP fee-for-service claims processing environment, generation of system edits and audits causes a claim to be suspended for review, pended to request additional information, or denied. In the shadow claims environment, claims are subjected to the same edit and audit criteria for data collection, utilization, and program comparison purposes. Because shadow claims have been fully adjudicated by the MCO, they adjudicate in Indiana*AIM* as paid or denied.

The fee-for-service edits and audits related to validity of the data, member eligibility, provider enrollment, or duplicate claim submissions are also active for shadow claims. Fee-for-service audits that limit the duration or frequency of specific services, restrict the place of service, or require prior authorization, are inactive or post and pay for shadow claims. Additionally, claims that are potential (but not exact) duplicates adjudicate as paid because the MCO has determined the validity of the paid claim prior to its submission as a shadow claim.

The disposition of each edit and audit applicable to shadow claims is recommended by the fiscal agent managed care director or designee and approved by the OMPP managed care director or designee. MCOs can request a review of the disposition of a specific edit or audit by submitting the *Edit/Audit Disposition Change Request Form* to the fiscal agent managed care director. *Appendix N: Edit/Audit Disposition Change Request Form* provides a sample of this form.

Generation of the fee-for-service edits and audits in the shadow claims processing environment causes claims to adjudicate with a paid or denied status in Indiana*AIM*, even though payments are not actually issued. Shadow claims are not suspended or pended for review because they are reports of claims payment adjudicated by the MCOs to their contracted and non-contracted providers.

Shadow Claims Output Documents

Indiana*AIM* acknowledges each shadow claim submitted by the MCO. This acknowledgment is one of the following:

- ECS biller summary report
- Electronic remittance advice (RA)

The ECS biller summary reports claims accepted into Indiana*AIM* for processing and claims rejected in the pre-cycle editing process described previously. Error code descriptions are found in the *ECS Manual*. This report is the basis for the application of liquidated damages applied at the discretion of

the OMPP if the acceptance rate falls below 98 percent for any single batch submission. Application of liquidated damages is discussed in more detail later in this section.

Electronic 835 RAs are generated for all claims adjudicated in Indiana*AIM*. Because shadow claims are adjudicated with either a paid or denied disposition, the RA for these claims indicates the disposition and the explanation of benefits (EOB) error code, if applicable.

The 835 is posted after the financial cycle is completed on the weekend, acknowledging the claims processed during the previous week's claim cycle. It is then available on the File Exchange server or the dial-up server (depending upon how the trading partner is set up). The 835s remain on the File Exchange server for 30 days unless the trading partner deletes them. The files remain on the dial-up server until the trading partner downloads are complete. The cut off time for claims to be included in the weekly financial cycle is Wednesday at 4 p.m.

Shadow Claims Corrections and Resubmissions

MCOs must develop a procedure to review the biller summary reports and RA files described previously to identify claims denied in either the precycle or adjudication processes. The biller summary report references error codes contained in the *ECS Manual*. The MCO can resubmit corrected claims in the next batch submission.

Correction methods for the edits and audits reported on the RA can be found in the *EDS Claims Resolution Manual*. Corrected claims must be resubmitted in the next batch submission. CMS-1500 claims containing both paid and denied details can be completely resubmitted or denied details only can be resubmitted. Resubmitted details on claims adjudicated with a paid status are denied as duplicates on the resubmission. UB-92 claims are not adjudicated at the detail level, so denied elements must be corrected and the entire claim resubmitted.

MCOs can bring questions about any aspects of shadow claims submission and adjudication to the monthly MCO technical meeting. This meeting, described in *Appendix D: Monthly MCO Technical Meeting Purpose and Structure*, is intended to provide a forum in which MCOs can have technical interface concerns addressed by the fiscal agent's technical staff. The meeting is held on the third Friday of each month. Inattention to correction and resubmission of denied shadow claims may result in assessment of liquidated damages described later in this section.

MCO Technical Resources Support

The MCO must report any problem it experiences with shadow claims submissions at the monthly MCO technical meeting. The purpose of the meeting, facilitated by EDS, is to provide a forum for MCO technical support staff to ask questions related to data exchange, shadow claims or other data interface issues. This meeting is regularly scheduled for the third Friday of each month. MCOs must forward agenda issues to the EDS Managed Care Unit representative one week before the meeting. To facilitate preparation for the meeting, agenda issues must include **specific and detailed examples** of problems to be discussed.

In addition, the MCO must report the measures it takes to correct shadow claims submission problems identified. The MCO must include a discussion of the quarter's claims submission problems and its corrective action plan and progress in the quarterly quality report that is submitted to the OMPP.

The current format for MCO technical meetings is in *Appendix D: Monthly MCO Technical Meeting Purpose and Structure*.

Shadow Claims Adjustments

While denied claims can be corrected and resubmitted as described previously, currently no process exists that allows an MCO to adjust or reverse an adjudicated claim with a paid status. This section will be updated on completion of the shadow claims adjustment or reversal process presently in development. Until the shadow claims adjustment process is implemented, **MCOs must not attempt to adjust a paid shadow claim by resubmitting a paid claim.**

Shadow Claims Liquidated Damages

Shadow claims reporting is an integral part of Hoosier Healthwise. As such, the OMPP retains the right to assess liquidated damages for an MCO's noncompliance with established standards for accurate and timely submission of shadow claims data. These standards are defined as follows:

- *Timeliness* – The filing limit for any shadow claim is 15 months from the first date of service on the claim. MCOs must comply with the established submission schedule agreed on between the MCO and the OMPP at the time of contracting. The schedule of submissions can be 90 days, 180 days, or 270 days from the date of service. For example, the negotiated schedule may require the MCO to submit 50 percent of shadow claims within 180 days from the date of service.

  The OMPP's goal is for MCOs to submit shadow claims as soon as possible, in less than 15 months from the first date of service on the claim. However, there may be barriers that prevent timely receipt of claims by MCOs from out-of-network providers. This delay also has an impact on the MCO's ability to submit shadow claims promptly. The purpose of the shadow claims submission schedule is to provide an estimate of the shadow claims to be submitted by MCOs at various times.

  An annual review of the MCO's rate of compliance with the established schedule for submitting shadow claims within 90, 180, and 270-day increments must be performed. The OMPP can assess liquidated damages of $200 per claim type, per percentage point of noncompliance. For example, if the established schedule indicates that 50 percent of claims would be submitted within 180 days, but the MCO's actual performance was 48 percent compliance, then liquidated damages of $400 may be assessed. Damages are assessed for each of the three time frames.

- *Completeness* – Each shadow claim is assessed for its compliance with precycle edits. For each batch of shadow claims submitted, 98 percent of the batch must pass all precycle edits. The remaining two percent must be corrected and resubmitted until a 100 percent accuracy rate is achieved. Each time the batch is resubmitted, it is treated as a new submission and checked for compliance with the 98 percent standard. Liquidated damages are assessed monthly, per claim type, for submissions that fall below the 98 percent standard.

  Failure to submit all claim types per month results in an assessment of liquidated damages of $2,000 for each claim type not submitted during that month.

- *Correctness* – For each claim type submitted in shadow claims in a calendar month, 90 percent of those claims must adjudicate with a paid status. Each resubmission is treated as a new submission for the calculation of paid or denied status. Ninty percent of all shadow claims must be adjudicated with a paid status within 15 months of the first date of service on the claim. Liquidated damages are assessed, by claim type, for submissions that fall below the 90 percent compliance standard. The OMPP recognizes that certain claims could be denied appropriately; therefore, it may not be possible at any time to attain 100 percent paid claims. However, the remaining 10 percent must be corrected and resubmitted with a goal of getting as close to 100 percent paid status as possible. For compliance levels lower than 90 percent, the schedule of liquidated damages shown in Table 9.2 is assessed.

- *Accuracy* – In addition, MCOs must ensure that shadow claims submissions are accurate. The OMPP requires that MCOs submit their internal criteria for determining claims payment accuracy

and the internal standard for an acceptable level of accuracy, as well as the monitoring plan for determining levels of accuracy. The monitoring plan must include a description of any liquidated damages, sanctions, or sanction-like provisions used to ensure accuracy of claims, and how often the MCO conducts its claims accuracy audits. The OMPP regularly monitors MCO shadow claims for accuracy against the MCO's internal criteria and level of accuracy submitted to the OMPP by the MCOs. The OMPP reserves the right to assess liquidated damages, similar to that described in the MCO monitoring plan for noncompliance. The MCO must submit the status and results of its internal Hoosier Healthwise claims audit to the OMPP. The OMPP reserves the right to re-audit claims or perform a random sample audit of all claims.

Third Party Liability Reporting

Federal regulations require that the OMPP's contract with risk-based managed care entities must specify activities performed by the MCO related to third party liability (TPL) requirements in *42 CFR 433, Subpart D*. MCOs are responsible for identifying and collecting TPL information, and can retain TPL collections because these amounts are included in capitation rate calculations.

EDS provides each MCO with a monthly list of the known TPL resources for its enrolled members. The jobs that create the MCO TPL files always run on the evening of the 20th of every month. The files are available for download from the File Exchange during the early morning hours of the 21st of each month. The following information is reported:

- Member name, RID, and Social Security number (SSN)
- Carrier name, address, phone number, and contact person
- Policyholder name, address, SSN, and relationship to member
- Policy number, effective date, and coverage type

The data on the monthly TPL file, as well as TPL information accessed via the automated eligibility systems (AVR, Omni) is limited to the most current information on file with the fiscal agent.

The fiscal agent obtains TPL information for a member from several sources including the following:

- Member's caseworker
- Health Management Services (HMS), the fiscal agent's subcontractor, identifies and reports to the fiscal agent the TPL information for Medicaid members.
- Other MCOs report TPL information through the monthly TPL file.
- Providers submit claims to the fiscal agent with other insurance information. When a claim is submitted to the fiscal agent with other insurance information, the fiscal agent sends a letter to the provider to confirm the TPL information.

The fiscal agent verifies for accuracy all TPL information it recieves (except when the information comes from the caseworker). Any TPL information found for a membercan be submitted to the fiscal agent using the *Provider TPL Referral Form* found at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. The completed form should be mailed t to the following address:

EDS TPL/Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262

The completed form may also be faxed to (317) 488-5217.

Each month, the MCO provides the same categories of information to the fiscal agent (EDS) that was not included in the fiscal agent's monthly list. This information includes:

- Newly discovered health insurance
- Any change in an enrollee's health insurance coverage
- Casualty insurance coverage

When the MCO becomes aware that an enrollee has instituted a legal cause of action for damages against a third party, the MCO sends written notification to the fiscal agent (EDS) that includes the following:

- Enrollee's name
- IHCP member identification number (RID)
- Date of accident or incident
- Nature of injury
- Name and address of enrollee's legal representative

In addition, the MCO also provides the fiscal agent with copies of pleadings and any other documents in its possession related to the action.

The MCO notifies the Division of Family Resources (DFR) within 30 days of the date the MCO becomes aware of the death of one of its Hoosier Healthwise enrollees and provides the following:

- Enrollee's full name
- Enrollee's address
- Enrollee's Social Security Number
- Enrollee's RID number
- Date of death

The MCO has no authority to pursue recovery against the estate of a deceased IHCP enrollee.

MCO TPL Responsibilities – Cost Avoidance

When the MCO is aware of health or casualty insurance coverage prior to paying for a health care service for an enrollee, the MCO can reject a provider's claim and direct that the claim be submitted first to the appropriate third party.

If insurance coverage is not available, or if one of the exceptions to the cost avoidance rule applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

The MCO must ensure that its cost avoidance efforts do not prevent an enrollee from receiving medically necessary services in a timely manner.

Cost Avoidance Exceptions

In the following situations, the MCO must first pay the provider and then coordinate with the liable third party:

- The coverage is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency, and the provider of service has not received payment from the third party within 30 days after the date of service.
- The claim is for prenatal care or for preventive pediatric services (including Early Periodic Screening, Diagnosis, and Treament or EPSDT) covered by the IHCP.
- The claim is for labor, delivery, and postpartum care and does not involve hospital costs associated with the inpatient hospital stay.

If the MCO was not aware of third party coverage at the time services were provided or paid for, the MCO can pursue reimbursement from potentially liable third parties.

Coordination of Benefits

If a commercial health or casualty insurer also covers an MCO's member, the MCO is fully responsible for coordinating benefits to maximize the use of third party coverage. The MCO is responsible for payment of the enrollee's co-insurance, deductibles, co-payments, and other cost-sharing expenses. The MCO's total payment must not exceed what the MCO would have paid in the absence of TPL.

Co-payments imposed by a primary payer for pharmacy services remain the responsibility of the MCO, regardless of the amount paid for the service by the primary insurer. This exception does not apply to deductibles or co-insurance amounts for pharmacy services or co-payments, deductibles, or co-insurance amount for any other service.

The MCO coordinates benefits and payments with the health or casualty insurer for services authorized by the MCO and provided outside the MCO's plan. Such authorization can occur prior to provision of service as long as any authorization requirements imposed on the enrollee or provider of service by the MCO do not prevent or delay an enrollee from receiving medically necessary services. The MCO remains responsible for the costs incurred by the enrollee with respect to care and services included in the MCO's capitation rate not covered or payable under the health or casualty insurer's plan.

Request for Member Disenrollment for TPL

If the IHCP enrollee's primary insurer is a commercial Health Maintenance Organization (HMO) and the Hoosier Healthwise-contracted MCO cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the MCO's rules, the MCO can submit a written request for disenrollment. The request must provide a specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker consults the OMPP and the request for disenrollment is considered and acted on promptly.

Casualty Cases

The MCO can exercise any independent subrogation rights it has under Indiana law in pursuit or collection of payments made for a legal cause of action for damages instituted by the enrollee or on behalf of the enrollee. Any recoveries made can be retained by the MCO, but must be reported to the OMPP.

Section 11: MCO Payment Process

Capitation Payments

MCOs receive per member per month (PMPM) capitation payments for enrolled members based on fixed rate cells assigned to each enrollee. In addition to the PMPM payment, MCOs receive reimbursement for each obstetric delivery reported on a shadow claim submission as described in *Section 10: Management Information Systems*. PMPM capitation rates, based on member age and gender, are grouped into capitation rate cells detailed in *Appendix O: MCO Capitation Rate Cells*.

As the fiscal agent for the Office of Medicaid Policy and Planning (OMPP), EDS generates monthly capitation payments to the Managed Care Organization (MCO) account identified on the electronic funds transfer (EFT) statement included with the initial MCO enrollment. This transfer occurs during the first financial cycle following the 15th day of the month. Concurrently, EDS posts the capitation roster via the 820 MCO Capitation Payment transaction, to the EDS File Exchange System, by MCO and region, which details the payment by capitation category. A schedule of actual capitation payment dates is distributed to the MCOs at the beginning of each year.

Each capitation payment includes prospective reimbursement for members enrolled in the MCO as of the first day of the same month. For example, the payment issued on or about the 15th of the month represents payment for members enrolled with the MCO on the first or 15th days of the current month.

Member effective dates with the MCO depend on the date the member's assignment to an MCO network PMP is entered in Indiana*AIM*. For newly-enrolled members in Hoosier Healthwise, PMP assignments entered from the 11th through the 25th of the current month are effective on the first day of the following month. New member PMP assignments entered from the 26th of the current month through the 10th of the following month are effective on the 15th of the following month. Incumbent Hoosier Healthwise members new to an MCO by virtue of a PMP change always have effective dates with the MCO on the first day of the month. PMP changes entered in Indiana*AIM* on or before the 25th day of the month have an effective date on the first day of the following month. PMP changes entered in Indiana*AIM* on or after the 26th day of the month are effective on the first day of the second month.

Because capitation payment is directly related to the enrollment process, Table 11.1 assists the MCO in reconciling the capitation payments to enrollment rosters.

Table 11.1 – Reconciling Capitation Payment to Enrollment Rosters

Enrollment roster effective date	Member status on enrollment roster	Member status for payment
15th	Add	Half capitation for current month
15th	Continuing	Full capitation for current month
15th	Terminated	Half capitation for current month for end date less than the 16th of the month.
First	Add	Full capitation for current month
15th of previous month	Terminated (death)	Capitation recouped for previous month
First of previous month(s) (newborn)	New	Full capitation for current month and full capitation for one or more retroactive months, depending on the date of birth compared to the report date
First	Deleted	No capitation payment

(Continued)

Table 11.1 – Reconciling Capitation Payment to Enrollment Rosters

Enrollment roster effective date	Member status on enrollment roster	Member status for payment
First	Terminated	No capitation payment
First	Continuing	Full capitation for current month

If a MCO identifies a discrepancy in the 820 MCO Capitation Payment transaction the MCO may contact the fiscal agent's managed care director.

Retroactive Capitation Payments

While capitation is usually a prospective payment system, there are provisions applicable to Indiana Health Coverage Programs (IHCP) enrollees that require payment of capitation to an MCO retroactively. Most retroactive capitation payments to an MCO are for newborns of mothers enrolled in the MCO on the date of delivery. Because the MCO was responsible for the mother's expenses related to the delivery, the MCO most likely incurred expenses related to the newborn's care. In these cases, the MCO receives a capitation payment for the newborn to cover each month retroactive to the birth month.

An eligibility record is established for a newborn whose mother is enrolled in an MCO, and Indiana*AIM* automatically assigns the newborn to a PMP in the mother's MCO. The timing of this assignment depends on how quickly the newborn's enrollment is processed through the caseworker and the Indiana Client Eligibility System (ICES) data is forwarded to the fiscal agent. For example, a child born on January 7, whose IHCP eligibility is finalized on February 17, receives eligibility retroactive to its date of birth. On receipt of the newborn's eligibility record, Indiana*AIM* determines whether the child's mother was enrolled in an MCO on the date of delivery by searching for the mother's member identification (RID) number, provided by ICES. If the mother is enrolled with an MCO, the newborn is automatically assigned to the preselected PMP in the MCO or another doctor within the same MCO. The effective date of the newborn's enrollment in the MCO is the date of birth. In this case, Indiana*AIM* receives the newborn's eligibility record on February 17. The system automatically searches for the eligibility of the mother whose RID is contained in the newborn's record. If the mother was enrolled in an MCO on the date of delivery, the newborn is automatically assigned to the preselected PMP or another appropriate PMP in the MCO network with an effective date of January 7.

On the MCO's next enrollment roster, dated February 26 for March 1 enrollees, the newborn appears with retroactive eligibility for the months of January and February as well as for the current month of March. On the MCO's next capitation payment, dated on or about March 15 for March 1 eligible members, the MCO receives retroactive payment for the months of January and February with a full month's capitation being paid for both months. The MCO receives full capitation payment for the birth month regardless of the actual date of birth. Additionally, the MCO receives a prospective capitation payment for the current month of March.

The MCO capitation payment listing described previously lists all members for whom capitation is paid for the current month. This report also details retroactive capitation and delivery capitation payments described below. Capitation category and payment or recoupment reason codes are listed in *Appendix M: MCO Capitation Cells.* The *820 MCO Capitation Payment Transaction Companion Guide* provides additional transaction details.

Delivery Capitation

In addition to the PMPM prospective capitation payment, MCOs receive an additional capitation payment for each enrolled member who gave birth on or after January 1, 1997. This additional payment is generated for the delivery during the month in which the MCO submits a shadow claim record of the delivery that adjudicates with a paid claim status. The delivery capitation payments are detailed on the monthly MCO capitation report.

The process for submission of shadow claims and the procedure codes, that generate the additional delivery capitation payment, are described in *Section 10: Management Information Systems*.

Capitation Adjustment

During the term of the State/MCO contract, adjustments to negotiated capitation rates may be appropriate. Interim adjustments can be either positive or negative and can be generated for an individual member or for a specific group, such as all members assigned to a capitation category on a specific date. At the discretion of the OMPP, the following *may* generate an adjustment to the negotiated capitation rates for an entire capitation category:

- Annual Consumer Price Index (CPI) that shows a general increase or decrease in medical expenses
- Addition of previously non-covered products and procedures to an MCO's financial liability
- Deletion of previously-covered products and procedures from an MCO's financial liability
- Other adjustments determined appropriate by the OMPP

The fiscal agent completes mass capitation adjustments at the direction of the OMPP. These adjustments are detailed on the MCO's monthly capitation report as positive or negative adjustments.

The following events may generate an adjustment to the capitation payments for an individual member:

- Duplicate capitation payment
- Capitation payments made after a member's date of death
- Adjustments to a member's eligibility

The MCO, fiscal agent, or the OMPP can identify the need for an individual capitation rate adjustment. An MCO wanting to request review of a member's capitation payments can send requests to the fiscal agent's Managed Care Director or designee. The fiscal agent completes all capitation adjustments a at the direction of the OMPP. These adjustments are detailed on the MCO's monthly capitation report as positive or negative adjustments.

Capitation Reconciliation

Capitation reconciliation occurs each month after the routine capitation payment cycle. The reconciliation process systematically compares member eligibility status to capitation payment history to identify discrepancies such as for retroactive benefit package or date of birth changes. Payment and recoupment adjustments then process through the following month's routine capitation cycle. Refer to *Appendix Q* for capitation adjustment reason codes.

Liquidated Damages

The OMPP assesses, and an MCO must pay, liquidated damages if an MCO fails to meet contractually-mandated performance or reporting requirements referred to in this manual. If an MCO fails to meet specified requirements, the OMPP sends a written notice to the MCO that identifies the unmet requirement and the amount of liquidated damages assessed. Unless stated otherwise, the MCO has 30 calendar days to send a check **payable to the Indiana Family and Social Services Administration (IFSSA)** to the OMPP managed care director, or designee, at the following address:

Name, Managed Care Director
Office of Medicaid Policy & Planning
402 W. Washington St., Room W 382, MS-07
Indianapolis, IN 46204-2739

Requests for waiver of liquidated damages are considered by the OMPP managed care director, or designee, on a case-by-case basis and must be submitted in writing to the address above. The request must include the MCO's rationale for the requested waiver.

Section 12: Children's Health Insurance Program

Overview

The *Balanced Budget Act of 1997* established the Children's Health Insurance Program (CHIP) as Title XXI of the *Social Security Act*. It allowed states to expand health insurance coverage to children whose family incomes exceed the requirements for Medicaid (known in Indiana as the Indiana Health Coverage Programs or IHCP), but are insufficient to afford private health insurance coverage.

Beginning July 1, 1998, Indiana implemented the first phase of CHIP as an expansion of Hoosier Healthwise, the IHCP managed care program. The first phase of the Hoosier Healthwise expansion provided health coverage to children one through eighteen years old with family incomes of no more than 150 percent of the FPL. Hoosier Healthwise members who became eligible for the program in the first phase of the CHIP expansion are subject to the same benefits, program policies, and network enrollment options as the traditional Hoosier Healthwise managed care population.

> *Note: For the purpose of this manual, there is no distinction made for this group of enrollees.*

Beginning January 1, 2000, Indiana implemented the second phase of CHIP for uninsured children younger than 19 years in families whose incomes are greater than 150, but less than 200 percent of the FPL. Members of this group are covered in the Hoosier Healthwise managed care program with the Package C plan of benefits.

> *Note: For the purpose of this manual, distinctions are made here for Package C benefits and policies to indicate variations from other Hoosier Healthwise managed care packages.*

Eligibility for Package C

Eligibility criteria for Package C include:

- The child is younger than 19 years old.
- The child's family income is greater than 150 and less than 200 percent of the FPL.
- The child does not have creditable health coverage for a three-month period prior to application for the program, unless such coverage was terminated involuntarily. If coverage was involuntarily terminated, then no waiting period for Hoosier Healthwise enrollment is necessary.
- The child's family satisfies all cost-sharing requirements.

Children born to Package C enrollees are not automatically covered on their date of birth, as are newborns to Hoosier Healthwise enrollees in other managed care packages. Newborns who qualify for Package C enrollment have coverage effective in the month of application.

Package C members are eligible for coverage beginning in the month of their application for Hoosier Healthwise and do not have up to three months of retroactive eligibility.

Enrollment in Package C

The application process for Package C is the same as other Hoosier Healthwise packages. After eligibility is determined, enrollment is conditional based on payment of a premium. After the premium is paid, eligibility information is transferred to Indiana*AIM*. Premiums are due monthly on the 12th of each month. Enrollment continues as long as the premium payments are received and the child continues to meet all other eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

Once enrolled, members are **required** to join a managed care plan. Hoosier Healthwise managed care network options are the same as for other Hoosier Healthwise enrollees. Members can select a primary medical provider (PMP) in a Managed Care Organization (MCO). Members who do not select a PMP within the first 30 days of eligibility are assigned to a PMP subject to the auto-assignment logic for Hoosier Healthwise managed care members described in *Section 7: Member Eligibility and Enrollment*.

Enrollment Rosters

Package C members are identified as such on MCO enrollment rosters, allowing MCOs to appropriately administer cost sharing and other benefit limitations that differ from their Hoosier Healthwise managed care enrollees in other benefit packages.

Package C members are not identified as such on PMP enrollment rosters. PMPs can verify eligibility and benefit limitations through the automated systems described in *Section 7: Member Eligibility and Enrollment*.

Cost Sharing

In addition to the premium payments described, families in Package C are also required to make co-payments for some services not required of members in other Hoosier Healthwise packages. Providers are responsible for collecting the co-payment amounts listed in Table 12.1.

Table 12.1 – Description of Co-payments

Service	Co-payment
Prescription drugs-generic, compound, and sole-source	$3
Prescription drugs – brand name	$10
Ambulance transportation	$10

Capitation Payment Categories

Capitation payments for Package C members are issued in one of the following capitation categories:

- CN – Newborns
- C1 – Preschool
- C6 – Children
- CT – Teenagers
- CD – Delivery payment

Capitation payments for Package C members are included on the monthly capitation payment listing with all other Hoosier Healthwise managed care enrollees. The capitation rates for Package C members are adjusted for variations in eligibility and benefit limitations.

Providers of Services

Providers enrolled in IHCP who deliver services to enrollees in other Hoosier Healthwise packages must also provide services to enrollees in Package C. Currently-enrolled PMPs in the Hoosier Healthwise managed care program also serve Hoosier Healthwise Package C members.

Benefit Limitations in Package C

The following services have coverage limitations in Package C that differ from those in other Hoosier Healthwise benefit packages:

- Early intervention services
- Physician services
- Podiatry services
- Chiropractic services
- Medical supplies and equipment
- Inpatient hospital
- Therapies – physical, speech, occupational, and respiratory
- Prescription drugs
- Inpatient rehabilitative services
- Mental health and substance abuse services
- Transportation

For Hoosier Healthwise benefit comparison refer to Chapter 2 of the *IHCP Provider Manual*.

Services Not Covered in Package C

The following services, covered for members in Hoosier Healthwise Package A, are not available to members enrolled in Package C.

- Nursing facility services
- Private duty nursing
- Community mental health rehabilitation
- Intermediate care facilities for the mentally retarded
- Case management for people with HIV/AIDS
- Case management for pregnant women
- Case management for the mentally ill or emotionally disturbed
- Non-ambulance transportation
- Christian Science nurses

- Christian Science sanatoriums
- Organ transplants
- Over-the-counter medications, except insulin
- Bed reservations in psychiatric hospital
- Inpatient mental health facilities with more than 16 beds

Appendix A: Managed Care Policy and Operations Meeting Purpose and Structure

Purpose

EDS facilitates a meeting bimonthly on the second Thursday of January, March, May, July, September, and November to provide a forum for discussion of new Hoosier Healthwise program policy and clarification of existing policy, as well as other matters of interest to participants in the Hoosier Healthwise program. Policy decisions are documented in Hoosier Healthwise Managed Care Policy Statements and included in program manuals and other communications as appropriate.

Participants

The following representatives participate in the Managed Care Policy and Operations meeting:

- Office of Medicaid Policy and Planning (OMPP) Managed Care Director and staff
- EDS Managed Care Unit staff
- Enrollment broker and PCCM administrator
- Managed Care Organizations (MCOs)
- MCO subcontractors as identified by the participating MCO
- HCE
- Representatives from other state agencies or organizations as invited by the OMPP

Structure

Each meeting follows a prepared agenda with MCO-submitted items as attachments to the agenda.

Agenda items must be submitted to EDS by noon the Monday of the week before the scheduled monthly meeting date.

MCOs must use the *Managed Care Policy and Operations Meeting Agenda Item Submission* form to submit agenda items. EDS will not accept requests for agenda items that are not submitted on the appropriate form.

EDS prepares the agenda with attachments and distributes it to attendees one week before the meeting date.

EDS writes meeting minutes and distribute them to all attendees with a copy of the agenda for the next meeting.

If necessary for a particular meeting, EDS provides a timekeeper for each agenda item to cover the items within the allotted meeting time.

Appendix B:Managed Care Policy Meeting Agenda Item Submission Form

The following is the appropriate form for submission of agenda items for the monthly managed care meeting:

MANAGED CARE MONTHLY MEETING AGENDA ITEM REQUEST

DATE:

PRESENTED BY:

SUMMARY/EXPLANATION OF AGENDA ITEM:

SUPPORTING DOCUMENTATION:
(State specific examples and rate of occurrence.)

IDENTIFY PROGRAM IMPACT/SYSTEMS IMPACT:
(Please state if unknown.)

DESIRED OUTCOME OR SUGGESTED RESOLUTION:

Appendix C:Monthly MCO Technical Meeting Purpose and Structure

Purpose

EDS facilitates a monthly meeting with the contracted Managed Care Organizations (MCOs) to provide technical support staff a forum in which to ask questions of their EDS counterparts regarding data exchange issues. MCOs may bring questions about their system interfaces for reading the electronic enrollment and capitation reports, reading the remittance advice (RA), experiencing issues with shadow claims submission, and any other matters requiring technical expertise. This meeting provides a resource for improvements in verbal and electronic communication between EDS and the participating Hoosier Healthwise MCOs.

Participants

The following representatives attend the Monthly MCO Technical meeting:

- EDS Managed Care staff
- Other EDS staff as needed
- OMPP Managed Care representative
- MCO technical support staff
- MCO subcontractor entities as identified by the participating MCO

Structure

Unless otherwise notified, the meeting is held at 1 p.m. on the third Friday of each month at EDS.

MCOs must prepare and submit written questions or issues to the designated EDS Managed Care staff member no later than 5 p.m. on the Friday before the meeting. Specific examples and explanations of issues to be researched must be included with the question.

The EDS Managed Care staff coordinates the meeting and arranges to have appropriate resources available to discuss the issues.

EDS compiles the agenda from the issues submitted by the MCOs. EDS or the Office of Medicaid Policy and Planning (OMPP) may add issues to the agenda as necessary, but in general, the agenda is generated from issues raised by the MCOs. EDS prepares and distributes minutes following each meeting.

If no issues are presented, or the number of issues does not warrant a meeting, EDS Managed Care staff notifies the contracted MCOs of cancellation by noon on the Thursday prior to the meeting. MCOs are responsible for communicating meeting changes or cancellations to their subcontracting entities.

MCOs must use the *Technical Meeting Agenda Item Request* form to submit agenda items. EDS does not accept requests for agenda items that are not submitted on the appropriate form.

Managed Care Technical Meeting
Agenda Item Request Form

Date:

Presented by:

Summary/explanation of technical agenda item:

Supporting documentation:

(State specific examples and rate of occurrence.)

Identify program or systems impact:

(Please state if unknown.)

Desired outcome or suggested resolution:

Will technical staff located off-site need to be conferenced-in?

YES **NO (circle one)**

Figure C.1 – Managed Care Technical Meeting Agenda Item Request Form

Appendix D: Family Planning Services

Family Planning Services

Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These include the following:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral and treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of contraceptive pills, devices, and supplies
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

Pap smears are included as a family planning service if performed according to the *United States Preventative Services Task Force Guidelines*, which specify cervical cancer screening every one to three years based on the presence of risk factors (early onset of sexual intercourse, multiple sexual partners). Pap smear annual frequency can be reduced if three or more annual smears are normal.

Based on CMS's Medicaid policies, initial STD diagnosis and treatment and HIV testing and counseling, if provided during family planning encounters, are considered part of family planning services. Ongoing follow-up of STDs and visits for treatment of chronic STDs are not part of family planning services.

Family planning services are self-referral under the Hoosier Healthwise Managed Care program but require appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) codes and *ICD-9-CM* diagnosis combinations to be billed on the paper CMS-1500 claim form..

Family Planning Billing Instructions:

Family Planning Codes Table D.2 – Diagnosis Codes and *Family Planning Codes* and *Table D.3 - Procedure Codes* include a list of family planning diagnosis and procedure codes that should be used as a guide when billing for family planning services provided to Hoosier Healthwise members without the member's PMP authorization. Providers must include a primary diagnosis code from Family Planning Codes Table A and a procedure code(s) from Family Planning Codes Table B to be reimbursed for family planning services without the PMP's authorization.

The following services are **NOT** reimbursable as family planning services:

1. Routine infertility studies or procedures
2. Reversal of voluntary sterilization
3. Hysterectomy for sterilization purposes only
4. All abortions, including but not limited to: therapeutic abortions; spontaneous, missed or septic abortions, and related services[1]
5. Transportation, parking, and childcare

Billing for other diagnosis and procedure codes must follow billing instructions as defined in the *Indiana Health Coverage Programs Provider Manual*. For more information on providing family planning services to Hoosier Healthwise members, please refer to the *Family Planning Services* portion of this manual.

Billing Codes for Family Planning Office Visits

The appropriate Evaluation and Management codes should be used for each initial and established office or outpatient visit. Providers should maintain appropriate documentation in the patient's record to identify the level of coding appropriate to the service provided.

Table D.1 identifies some of the office visit codes available for billing family planning services.

Table D.1 – Office Visit Codes for Family Planning

Family Planning Visit Type	CPT Codes	Comments
Initial	99201-99205	
Established Patient	99211-99215	
Re-supply Only	99211	This visit code can be billed when a contraceptive client visit does not involve a physical examination or counseling. Example of this visit type is oral contraceptive refill visit.

Table D.2 – Family Planning Diagnosis Codes

Diagnosis Code Description	Diagnosis Code
CONTRACEPTIVE MANAGEMENT	V25
CONTRACEPTIVE MANAGEMENT - COUNSEL	V25
PRESCRIPTION OF ORAL CONTRACEPTIVES	V2501
INITIATION OF OTHER CONTRACEPTIVE MEASURES	V2502
CONTRACEPTIVE MANAGEMENT NEC	V2509
INTRAUTERINE DEVICE (IUD) INSERTION	V251
MENSTRUAL EXTRACTION	V253
CONTRACEPTIVE SURVEILLANCE	V254

(Continued)

[1] Pregnancy testing and counseling performed by family planning providers are reimbursable regardless of member's decision for abortion.

Table D.2 – Family Planning Diagnosis Codes

Diagnosis Code Description	Diagnosis Code
CONTRACEPTIVE SURVEILLANCE, NOS	V2540
CONTACEPTIVE PILL SURVEILLANCE	V2541
INTRAUTERINE DEVICE (IUD) SURVEILLANCE	V2542
CONTRACETPIVE SURVEILLANCE NEC	V2549
INSERTION AND SURVEILLANCE	V255
CONTRACEPTIVE MANAGEMENT NEC	V258
CONTRACEPTIVE MANAGEMENT NOS	V259
EARLY SYMPTOMATIC SYPHILIS	091
PRIMARY GENITAL SYPHILIS	0910
PRIMARY ANAL SYPHILIS	0911
PRIMARY SYPHILIS NEC	0912
SECONDARY SYPH SKIN	0913
LATE SYMPTOMATIC SYPHILIS NEC	0958
LATE SYMPTOMATIC SYPHILIS NOS	0959
LATE SYPHILIS, LATENT	096
OTHER AND UNSPECIFIED SYPHILIS	097
LATE SYPHILIS NOS	0970
LATENT SYPHILIS NOS	0971
SYPHILIS NOS	0979
GONOCOCCAL INFECTIONS	098
ACUTE GC INFECTIONS LOWER GU	0980
ACUTE GC INFECTIONS UPPER GU	0981
GC INFECTIONS UPPER GU NOS	09810
GC CYSTITIS (ACUTE)	09811
GC PROSTATITIS (ACUTE)	09812
GC ORCHITIS (ACUTE)	09813
GC SEMINAL VESICULITIS (ACUTE)	09814
GC CERVICITIS (ACUTE)	09815
GC ENDOMETRITIS (ACUTE)	09816
GC SALPINGITIS (ACUTE)	09817
GC INFECCTIONS UPPER GU NEC	09819
CHLAMYDIA VAGINITIS (ACUTE)	09953
VENEREAL NEC URETHRITIS	09940
OTHER VENEREAL DISEASE	099
CHANCROID	0990

(Continued)

Table D.2 – Family Planning Diagnosis Codes

Diagnosis Code Description	Diagnosis Code
LYMPHOGRANULOMA VENEREUM	0991
GRANULOMA INGUINALE	0992
REITER'S DISEASE	0993
NONGONOCOCC URETHRIT NEC	0994
UNSPECIFIED NONGONOCOCCAL	09940
VENEREAL URETHRITIS DUE TO	09941
DUE TO OTHER SPECIFIED OR	09949
CHLAMYDIA TRACHOMATIS INF	09950
CHLAMYDIA TRACHOMATIS INF	09951
CHLAMYDIA TRACHOMATISINFE	09952
CHLAMYDIA TRACHOMATIS INF	09953
CHLAMYDIA TRACHOMATIS INF	09954
CHLAMYDIA TRACHOMATIS INF	09955
CHLAMYDIA TRACHOMATIS INF	09956
CHLAMYDIA TRACHOMATIS INF	09959
VENEREAL DISEASE NEC	0998
VENEREAL DISEASE NOS	0999

Table D.3 – Family Planning Procedure Codes

Procedure Code Description	Procedure Code
AUTOMATED MULTICHANNEL TEST (1 OR 2 CHEMISTRY TESTS)	80002
AUTOMATED MULTICHANNEL TEST (3 CHEMISTRY TESTS)	80003
AUTOMATED MULTICHANNEL TEST (5 CHEMISTRY TESTS)	80005
BLOOD COUNT; SPUN MICROHEMATOCRIT	85013
CHLAMYDIA; ANTIBODIES	86632
CHLAMYDIA; CULTURE	87110
CHOLESTEROL, SERUM; TOTAL	82465
CULTURE, BACTERIAL, DEFINITIVE IDENTIFICATION	87076
CULTURE, BACTERIAL, DEFINITIVE; ANY OTHER SOURCE	87070
CULTURE, BACTERIAL, DEFINITIVE; ANY SOURCE; ANAEROBIC	87075
CULTURE, BACTERIAL, DEFINITIVE; BLOOD	87040
CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE	88160
CYTOPATHOLOGY, SMEARS, CERVICAL OR VAGINAL	88150
DEPOP-PROVERA 150MG	X3023

(Continued)

Table D.3 – Family Planning Procedure Codes

Procedure Code Description	Procedure Code
DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS	57170
FAMILY PLANNING SERVICE	W0660
GLUCOSE; POST GLUCOSE DOSE	82950
GLUCOSE; QUANTITATIVE	82947
GONADOTROPIN, CHORIONIC; QUALITATIVE	84703
GONADOTROPIN, CHORIONIC; QUANTITATIVE	84702
HANDLING AND/OR CONVEYANCE OF SPECIMEN	99000
HIV ANTIGEN TEST	86311
HTLV, ANTIBODY DETECTION	86689
IMMUNOASSAY FOR INFECTIOUS AGENT ANTIBODY, QUANTITATIVE	86317
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), INSERTION	X3000
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), REMOVAL	X3001
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), REMOVAL WITH REINSERT. (Same Sight)	X3002
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), REMOVAL WITH REINSERT. (New Sight)	X3003
(Following Norplant Codes Effective April 1, 2002)	
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), INSERTION	11981
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), REMOVAL 1	1982
IMPLANTABLE CONTRACEPTIVE CAPSULE (NORPLANT), REMOVAL WITH REINSERT.	11983
INDUCED ABORTION, BY D&C (MUST FOLLOW STATE AND FEDERAL GUIDELINES)	59840
INDUCED ABORTION, BY D&E (MUST FOLLOW STATE AND FEDERAL GUIDELINES)	59841
INJECTION, MEDROXYPROGEST	J1055
INSERTION OF INTRAUTERINE DEVICE (IUD)	58300
LEGEND BIRTH CONTROL (PLANNED PARENTHOOD ONLY)	W0660
LIGATION OR TRANSECTION OF FALLOPIAN TUBES (MUST FOLLOW STATE AND FEDERAL GUIDELINES)	58600
LIPID PROFILE	80061

(Continued)

Table D.3 – Family Planning Procedure Codes

Procedure Code Description	Procedure Code
NON-LEGEND BIRTH CONTROL (PLANNED PARENTHOOD ONLY)	W0670
OFFICE VISIT, REVISIT, ESTABLISHED PATIENT--SEE BILLING CODES FOR OFFICE VISITS OR OUTPATIENT SERVICES	99211-99215
OFFICE VISIT, INITIAL – SEE BILLING CODES FOR FP OFFICE VISITS	99201-99205
OFFICE VISIT, RESUPPLY -- SEE BILLING CODES FOR FP OFFICE VISITS	99211
PLATELET; ESTIMATION ON SMEAR	85585
RBC SED RATE, AUTOMATED	85652
REMOVAL OF INTRAUTERINE DEVICE (IUD)	58301
SKIN TEST; TUBERCULOSIS, INTRADERMAL	86580
SMEAR, PRIMARY SOURCE, WITH INTERPRETATION; FLUORESCENT STAIN	87206
SMEAR, PRIMARY SOURCE, WITH INTERPRETATION; ROUTINE STAIN	87205
SMEAR, PRIMARY SOURCE, WITH INTERPRETATION; SPECIAL STAIN	87207
SMEAR, PRIMARY SOURCE, WITH INTERPRETATION; WET MOUNT	87210
SYPHILIS TEST; QUALITATIVE	86592
TRIGLYCERIDES, BLOOD	84478
URINALYSIS, BY DIP STICK WITH MICROSCOPY	81000
URINALYSIS, MICROSCOPIC ONLY	81015
URINALYSIS, WITHOUT MICROSCOPY, NON-AUTOMATED	81002
URINALYSIS, AUTOMATED WITH SCOPE	81001
URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON	81025
VASOTOMY, CANNULAZATION WITH OR WITHOUT INCISION OF VAS. UNILATERAL OR BILATERAL	55200
VASECTOMY, UNILATERAL OR BILATERAL (MUST FOLLOW STATE & FED. GUIDELINES)	55250
VIRUS IDENTIFICATION; TISSUE CULTURE INOCULATION AND OBSERVATION	87252
SUPPLIES AND MATERIALS PROVIDED BY THE PHYSICIAN (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)	99070
SERUM PREGNANCY TEST (QUANTITATIVE) (βHCG)	84702
SERUM PREGNANCY TEST (QUALITATIVE) (βHCG)	84703

(Continued)

Table D.3 – Family Planning Procedure Codes

Procedure Code Description	Procedure Code
THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); SUBCUTANEOUS OR INTRAMUSCULAR	90782

Table D.4 – Family Planning ICD-9-CM Diagnosis Codes

Family Planning Service	Appropriate ICD-9 Diagnosis Codes
Contraceptive Management-Counsel	V250
Prescription of Oral Contraceptives	V2501
Initiation of Other Contraceptive Measures	V2502
Contraceptive Management NEC	V2509
Intrauterine Device (IUD) Insertion	V251
Menstrual Extractor	V253
Contraceptive Surveillance	V254
Contraceptive Surveillance, NOS	V2540
Contraceptive Pill Surveillance	V2541
IUD Surveillance	V2542
Implantable subdermal contraceptive	V2543
Contraceptive Surveillance NEC	V2549
Insertion and Surveillance	V255
Contraceptive Management NEC	V258
Contraceptive Management NOS	V259

Physicians and family planning clinics may bill contraceptive pills, devices, and supplies, including Norplant, using the appropriate National Drug Codes (NDCs) on the pharmacy claim form. (Refer to the *Indiana Health Coverage Programs Provider Manual* for pharmacy claim form billing instructions for legend and non-legend birth control items. Also refer to the State of Indiana Over-the-Counter (OTC) Drug Formulary and Drug Efficacy Study and Implementation (DESI) listings of Medicaid-billable NDCs.)

Services and supplies without an NDC can be billed using the papger CMS-1500 claim form. These services must be billed using appropriate CPT and HCPCS codes and appropriate *ICD-9 CM* diagnoses for services provided or conditions treated. For example, for contraceptive management use *V25.01-V25.9* and for acute chlamydial vaginitis use *099.53*.

When using CPT code 99070 for supplies dispensed during a family planning visit, the name of the item dispensed must be identified below the line item being billed on the paper CMS-1500 claim form. The quantity (number of packages) dispensed must be identified in field 24G. The amount billed must reflect the appropriate cost of the contraceptive item and must not exceed the NDC packaging price.

The member's chart must contain the date of the office visit, the NDC and name of the product dispensed as well as the number of items dispensed (for example, four boxes of 30 items).

Appendix E: Sample Written Referral Form

This form is a suggested format for written referrals. Its use is optional. Referrals must be documented in the patient's medical record. This form does not need to be submitted with the claim for the rendered service.

REFERRAL FOR HOOSIER HEALTHWISE MANAGED CARE MEMBER

Date: _____

To: _____

From: _____

Provider #: _____

Address: _____

Phone: _____

Patient's Name _____

Medicaid or RID #: _____

Purpose of Referral: _____

_____

_____

_____

Extent of Referral (Check one):

[ ] One time only

[ ] As needed for treatment. (A new form or verbal authorization must be obtained prior to every calendar quarter).

[ ] Other, please specify:

This member is enrolled with me as his/her Primary Medical Provider (PMP). Please keep me informed of the disposition of the patient following your contact. As the patient's PMP, my medical records must reflect a complete health history. If you wish to refer this patient to another treatment source that will be billing Medicaid, please contact me.

By: _____

Primary Medical Provider

Figure E.1 – Written Referral Form

Appendix F: PMP Disenrollment Timeline

Submission of PMP Disenrollment Requests to EDS

Each Managed Care Entity (MCE) provides the EDS Managed Care Unit with a list of representatives who are trained and authorized to submit primary medical provider (PMP) disenrollments and keeps their lists updated as responsibilities change.

An MCE notifies the EDS PMP disenrollment coordinator of the intent to disenroll a PMP within five working days of receipt or issuance of the disenrollment request. EDS does not process the disenrollment until the MCE sends the disenrollment request. Advance notification allows EDS the opportunity to begin the coordination of enrollment in another network, if necessary.

MCEs submit fully-completed requests for disenrollment to the EDS PMP disenrollment coordinator at least five working days prior to the 24th day of the month. Managed Care Organization (MCO) network disenrollments are processed on the 24th day of the month. The following table lists the last day on which the EDS Managed Care Unit must receive the request to be effective by the first day of the following month.

Table G.1 – PMP Disenrollment Request Deadlines

Effective Date	Received on or Before
January 1, 2006	December 16, 2005
February 1, 2006	January 17, 2006
March 1, 2006	February 17, 2006
April 1, 2006	March 17, 2006
May 1, 2006	April 17, 2006
June 1, 2006	May 17, 2006
July 1, 2006	June 16, 2006
August 1, 2006	July 17, 2006
September 1, 2006	August 17, 2006
October 1, 2006	September 15, 2006
November 1, 2006	October 17, 2006
December 1, 2006	November 17, 2006
January 1, 2007	December 15, 2006

Appendix G: Hoosier Healthwise PMP Panel Size/Panel Hold Cover Form – Update

Hoosier Healthwise
Primary Medical Provider (PMP) Panel Size/Panel Hold Cover Form –Update

Please complete every field on this form and submit to the EDS Managed Care Unit. You must submit all required documentation with this form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's panel size update. Note: A panel size increase greater than the maximum 2,000 or a panel size decrease lower than the minimum 150 must have written OMPP approval.

Date submitted to EDS _____ MCE Requester: ☐ *AmeriChoice* ☐ *Amerigroup*
MCE contact Name _____ ☐ *MHS* ☐ *CareSource*
MCE contact phone number _____ ☐ *MDwise* ☐ *Molina*
MCE contact e-mail _____ ☐ *Harmony*

1. Provider Name _____
2. Indiana Health Coverage Program provider number, must be 9 digits _____

A. Panel Size Increase request? Yes ☐ Increase panel size to _____
B. Panel Size Decrease request? Yes ☐ Decrease panel size to _____
C. Panel Hold request? Yes ☐ Panel Hold effective date _____
D. Panel Hold Remove request? Yes ☐ Panel Remove effective date _____

OMPP Use Only (Requests for panel size lower than 150 or greater than 2,000 must be approved by the OMPP Managed Care Director)

Approved Yes ☐ No ☐

"I authorize the above request for a panel size of _____members"

OMPP Managed Care Director Name _____ Date Approved _____

Comments _____

EDS Use Only

Date Received _____ Date Request Processed _____ Date QC'd _____

***Note**

Panel Size Requests: *A PMP must choose to accept between 150 and 2000 Hoosier Healthwise members, with the exception of OB/GYN PMPs in rural counties who may decrease the limit to 50 (Panel size lower than the required 150 must be authorized by OMPP). The PMP must notify the MCE in writing of this request. If the PMP's current enrollment exceeds the new, reduced panel size, the panel size will not automatically decrease to the new desired size. Previous PMP and Case ID logic will continue to auto assign members to the PMP. However, no new members will be assigned. MCEs should be sure their PMP's understand this. Required documents: PMP Panels Size/Hold cover form- update, MCE PMP panel size request form (if applicable) and the PMP's signed letter of request.*

Panel Hold Requests: *A PMP may elect to temporarily freeze their panel to new enrollments. The PMP must notify the MCE in writing of this request. The PMP's signature letter request must indicate the effective date of the hold and document the reason for the request. The request is then forwarded to the EDS Managed Care Unit for processing. Please note that previous PMP and case ID auto assignment logic override a panel hold status.* MCEs should be sure their PMP's understand this. *Required documents: PMP Panels Size/Hold cover form- update, MCE PMP panel size request form (if applicable) and the PMP's signed letter of request.*

Version: October 2004

Figure G.1 – Hoosier Healthwise PMP Panel Size/Panel Hold Cover Form – Update

Appendix H: MCO PMP Enrollment Sheet

(MCO Name is listed here)
MCO Primary Medical Provider (PMP) Enrollment Cover Form – New Enrollment

Please complete every field on this form and submit to the EDS Provider Enrollment Unit. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.

Date submitted to EDS _____ MCO contact name _____
MCO contact phone number _____ MCO contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐
B. Is the PMP enrolling into an MCO and also continuing enrollment in PCCM? Yes ☐ No ☐ Unknown ☐

1. Provider name _____
2. A. Indiana Health Coverage Program provider number, must be 9 digits _____
   B. Indiana provider license number (if known/optional) _____
3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP
   Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4
4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5
5. PMP may have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.
   A. First service location address, including county name, and daytime phone number
   B. Second service location address, including county name, and daytime phone number (if applicable)

6. Please indicate the PMP's specialty type:
   Family Practitioner ☐ OB/GYN ☐ General Pediatrics ☐
   General Practice ☐ General Internal Medicine ☐
7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐
8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐
9. Age restrictions (Please check one per service location)
   Location 1 None ☐ 0-2 years ☐ 0-12 years ☐ 0-17 years ☐ 0–20 years ☐ 13+ years ☐
   13-17 years ☐ 13-20 years ☐ 21+ years ☐ 3+ years ☐ 17+ years ☐
   Location 2 None ☐ 0-2 years ☐ 0-12 years ☐ 0-17 years ☐ 0–20 years ☐ 13+ years ☐
   13-17 years ☐ 13-20 years ☐ 21+ years ☐ 3+ years ☐ 17+ years ☐
10. Please indicate PMP scope of practice:
    Families Yes ☐ **No** ☐ **Obstetrics Yes** ☐ **No** ☐ **All women (OB/GYN) Yes** ☐ **No** ☐
    OB/GYN (OB only) Yes ☐ **No** ☐
11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____
12. Desired effective date of enrollment

Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure H.1 – MCO PMP Enrollment Cover Form – New Enrollment

[MCO Name Goes Here]

RBMC Primary Medical Provider (PMP) Enrollment Cover Form – Enrollment Update

*Please complete every field on this form and submit to the **EDS Provider Enrollment Unit**. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.*

Date submitted to EDS _____ [MCO] contact name _____

[MCO] contact phone number _____ [MCO] contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐

B. Is the PMP enrolling into RBMC and also continuing enrollment in PCCM? Yes ☐ No ☐ Unknown ☐

1. Provider name _____
2. A. Indiana Health Coverage Program provider number, must be 9 digits _____
   B. Indiana provider license number (if known/optional) _____
3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP
   Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4
4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5
5. PMP may have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.
   A. First service location address, including county name, and daytime phone number
   B. Second service location address, including county name, and daytime phone number (if applicable)

6. Please indicate the PMP's specialty type: **Family Practitioner** ☐ **OB/GYN** ☐ **General Pediatrics** ☐ **General Practice** ☐ **General Internal Medicine** ☐
7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐
8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐
9. Age restrictions (Please check one per service location)

Location 1	None ☐	0-2 years ☐	0-12 years ☐	0-17 years ☐	0–20 years ☐	13+ years ☐
	13-17 years ☐	13-20 years ☐	21+ years ☐	3+ years ☐	17+ years ☐	
Location 2	None ☐	0-2 years ☐	0-12 years ☐	0-17 years ☐	0–20 years ☐	13+ years ☐
	13-17 years ☐	13-20 years ☐	21+ years ☐	3+ years ☐	17+ years ☐	

10. Please indicate PMP scope of practice:
    Families Yes ☐ No ☐ **Obstetrics** Yes ☐ No ☐ **All women (OB/GYN)** Yes ☐ No ☐
    OB/GYN (OB only) Yes ☐ No ☐
11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____
12. Desired effective date of enrollment _____

Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure H.2 – MCO PMP Enrollemnt Cover Form – Update Enrollment

Appendix I:PMP Correspondence

This section includes samples of correspondence sent to primary medical providers (PMPs).

Date

Recipient's First and Last Name
Recipient Address
Recipient Address
Recipient Address (or blank if not needed)

Dear Hoosier Healthwise Member:

Welcome to the Hoosier Healthwise Program! Starting MM/DD/CCYY you will become a patient with the doctor you have chosen. Our records show that the doctor you chose is:

Dr. PMP Name
Address
Address
Address (or blank if not needed)

Phone: (XXX) XXX-XXXX

Health Plan: MCO Name – MCO Network

Your doctor is in the health plan listed above. Your doctor will treat you when you are ill, and arrange for specialists or hospital care if you need it. Check with your doctor before you get prescriptions or any health care. You may call your health plan's member helpline at 1-XXX-XXX-XXXX if you have any questions about your doctor or how to get health care in your health plan.

Please call your doctor when you receive this letter so that you can set up your first appointment.

Your doctor, or someone who works with your doctor, can be reached anytime, day or night, to help you with your medical problems. This 24-hour access will prevent you from having to go to the emergency room unless it is a true emergency! Call your doctor's office for advice if you are not sure your condition is an emergency.

Sincerely,

The Hoosier Healthwise Program

P.S. You should receive your member handbook soon. Please read it for important information about the Hoosier Healthwise program. If you have any questions about the program, please call the Hoosier Healthwise Helpline at 1-800-889-9949. Also remember to take your Hoosier Health card when you go to your doctor's office.

Your ID number is **********.

Figure I.1 – Welcome Letter A

Date

Recipient's First and Last Name
Recipient Address
Recipient Address
Recipient Address (or blank if not needed)

Dear Hoosier Healthwise Member:

Welcome to the Hoosier Healthwise Program! Our records show that you have not chosen a doctor, so we have assigned you to one. Starting MM/DD/CCYY, your doctor is:

Dr. PMP Name
Address
Address
Address (or blank if not needed)

Phone: (XXX) XXX-XXXX

Health Plan: MCO Name – MCO Network

Your doctor is in the health plan listed above. Your doctor will treat you when you are ill, and arrange for specialists or hospital care if you need it. Check with your doctor before you get prescriptions or any health care. You may call your health plan's member help line at 1-XXX-XXX-XXXX if you have any questions about your doctor or how to get health care.

Please call your doctor when you receive this letter so that you can set up your first appointment. If you wish to pick a different doctor, please call your member help line.

Your doctor, or someone who works with your doctor, can be reached anytime, day or night, to help you with your medical problems. This 24-hour access will prevent you from having to go to the emergency room unless you have a true emergency! Call your doctor's office for advice if you are not sure your condition is an emergency.

Sincerely,

The Hoosier Healthwise Program

P.S. You should receive your member handbook soon. Please read it for important information about the Hoosier Healthwise program. If you have any questions about the program, please call the Hoosier Healthwise Helpline at 1-800-889-9949. Also remember to take your Hoosier Health card when you go to your doctor's office.

Your ID number is **********.

Figure I.2 – Welcome Letter B

Date

Recipient's First and Last Name
Recipient Address
Recipient Address
Recipient Address (or blank if not needed)

Dear Hoosier Healthwise Member:

Welcome to the Hoosier Healthwise Program! Our records show that you have not chosen a doctor. We have selected one for you based on your, or your family's, previous Hoosier Healthwise enrollment and/or participation. Starting MM/DD/CCYY your doctor is:

Dr. PMP Name

Address
Address
Address (or blank if not needed)

Phone: (XXX) XXX-XXXX

Health Plan: PrimeStep *(or)* MCO Name – MCO Network

Your doctor is in the health plan of medical providers listed above.

You may call your health plan's member help line at 1-XXX-XXX-XXXX if you have any questions about your doctor or how to get health care in your health plan. If you would like to choose another doctor for any reason, please call the member helpline.

Please call your doctor when you receive this letter so that you can set up your first appointment. Regular health checks are a good way to stay healthy. Your doctor will treat you when you are ill, and arrange for specialists or hospital care if you need it. Check with your doctor before you get prescriptions or any health care.

Your doctor, or someone who works with your doctor, can be reached anytime, day or night, to help you with your medical problems. This 24-hour access will prevent you from having to go to the emergency room unless you have a true emergency! Call your doctor's office for advice if you are not sure your condition is an emergency.

Sincerely,

The Hoosier Healthwise Program

P.S. You should receive your member handbook soon. Please read it for important information about the Hoosier Healthwise program. If you have any questions about the program, please call the Hoosier Healthwise Helpline at 1-800-889-9949. Also remember to take your Hoosier Health card when you go to your doctor's office.

Your ID number is **********.

Figure I.3 – Welcome Letter C

Date

Recipient's First and Last Name
Recipient Address Line 1
Recipient Address Line 2
Recipient City, State, Zip code

Dear Hoosier Healthwise Member:

Effective MM/DD/CCYY your current Hoosier Healthwise doctor will no longer be participating as a Primary Medical Provider (PMP) in Hoosier Healthwise. This is to let you know you must select another Hoosier Healthwise personal doctor or one will be chosen for you.

You must call your health plan's Member Services number at 1-xxx-xxx-xxxx to select your new doctor in MCO Name.

Sincerely,

The Hoosier Healthwise Program

Figure I.4 – RBMC PMP Mandatory Disenrollment Letter to Member

Date

Recipient's First and Last Name
Recipient Address Line 1
Recipient Address Line 2
Recipient City, State, Zip code

Dear Hoosier Healthwise Member:

Effective MM/DD/CCYY your current Hoosier Healthwise doctor will no longer be participating in the Hoosier Healthwise program. This is to let you know that starting MM/DD/CCYY, your new Hoosier Healthwise personal doctor will be:

Dr. PMP Name
PMP's Address
PMP's Address
PMP's Address

PMP Phone

Health Plan: PrimeStep *(or)* MCO Name – MCO Network

This is the doctor you will go to for your medical care. Because you are a Hoosier

Healthwise member, your personal doctor is available 24 hours a day, 7 days a week.

Most important to you, your personal doctor can give you medical care for your individual health care needs. Your personal doctor will treat you, and arrange for visits to specialists and hospital care when you need it.

As a Hoosier Healthwise member, you should see your personal doctor before you go anywhere else for medical care. You do not need to go to the emergency room unless it is a true emergency; if you are unsure, call your Hoosier Healthwise doctor for advice.

If you have any questions about Hoosier Healthwise, either call your personal doctor at the phone number listed above or call your health plan's Member Services at phone of new PMP's delivery system.

Sincerely,

The Hoosier Healthwise Program

Figure I.5 – PMP Disenroll-Member Autoassigned (Disenrollment Code Other than MCE/SL change)

Date

PMP Contact Name
PMP Address
PMP Address
PMP Address (or blank if not needed)

Health Plan: MCO Name – MCO Network

Dear PMP:

Effective MM/DD/CCYY, you will no longer be participating in the Hoosier Healthwise plan listed above.

You are being disenrolled due to Disenrollment Reason.

You are responsible for members assigned to you under the Risk Based Managed Care program until MM/DD/CCYY.

If you have any questions regarding your disenrollment from Hoosier Healthwise, please contact:

MCO Name

1-XXX-XXX-XXXX.

Sincerely,

The Hoosier Healthwise Program

Figure I.6 – RBMC PMP Mandatory Disenrollment Letter to PMP

Date

PMP Contact Name
PMP Address
PMP Address
PMP Address (or blank if not needed)

Health Plan: MCO Name – MCO Network

Dear PMP:

Effective MM/DD/CCYY, you will no longer be participating in the Hoosier Healthwise plan listed above.

You are being disenrolled from the program per your request. You are responsible for members assigned to you under the Risk Based Managed Care program until MM/DD/CCYY.

If you have any questions regarding your disenrollment from Hoosier Healthwise, please contact:

MCO Name

1-XXX-XXX-XXXX.

Sincerely,

The Hoosier Healthwise Program

Figure I.7 – RBMC PMP Voluntary Disenroll Letter to PMP

Date

MCO Contact Name
MCO Name
MCO Address Line 1
MCO Address Line 2
MCO City, MCO State, MCO Zip

Dear MCO Contact Name:

The following Primary Medical Provider will no longer be in your health plan in Hoosier Healthwise:

Effective Date: MM/DD/CCYY

PMP Name: Name of PMP being disenrolled

Disenrollment Reason: Disenrollment Reason

If you have any questions regarding the disenrollment of this PMP please contact the Managed Care unit at EDS.

Sincerely,

The Hoosier Healthwise Program

Figure I.8 – RBMC Mandatory PMP Disenrollment Letter to MCO

Date

MCO Contact Name
MCO Name
MCO Address Line 1
MCO Address Line 2
MCO City, MCO State, MCO Zip

Dear MCO Contact Name:

The following Primary Medical Provider will no longer be in your health plan in Hoosier Healthwise:

Effective Date: MM/DD/YY

PMP Name: Name of PMP being disenrolled

Disenrollment Reason: Disenrollment Reason

If you have any questions regarding the disenrollment of this PMP please contact the Managed Care unit at EDS.

Sincerely,

The Hoosier Healthwise Program

Figure I.9 – RBMC Voluntary PMP Disenrollment Letter to MCO

Date

Member's First and Last Name
Member Address Line 1
Member Address Line 2
Member City, State, Zip code

Dear Hoosier Healthwise Member:

Your Hoosier Healthwise doctor is changing health plans. You are still enrolled in the Hoosier Healthwise program.

Effective MM/DD/CCYY, your health plan network may have changed or your doctor may have changed. This is to let you know that your doctor is:

Dr. PMP NAME

PMP Address
PMP Address
PMP Address (or blank if not needed)

PMP Phone: (XXX) XXX-XXXX

Health Plan: PrimeStep *(or)* MCO Name – MCO Network

Your doctor is in the Hoosier Healthwise health plan listed above.

Your doctor will treat you when you are ill. Your doctor will also arrange for other care, if you need it. Your doctor's health plan network may be different for some services, such as pharmacies and transportation.

If you have any questions, please call the Member Services for PMP's Network Name at 1-XXX-XXX-XXXX. Or you may also call the Hoosier Healthwise Helpline at 1-800-889-9949.

Sincerely,

The Hoosier Healthwise Program

P.S. If your doctor changed health plans, you should receive your new member handbook soon. Please read it for important information about the Hoosier Healthwise program. Also remember to take your Hoosier Health card when you go to your doctor's office.

Figure I.10 – PCCM PMP Disenrollming-Re-enrolling in RBMC Letter to Member; RBMC PMP Disenrolling-Re-enrolling in PCCM Letter to Member; RBMC PMP Disenrolling-Re-enrolling in Another RBMC Network Letter to Member

Date

Member's First and Last Name
Member Address Line 1
Member Address Line 2
Member City, State, Zip code

Dear Hoosier Healthwise Member:

Your Hoosier Healthwise doctor is changing health plans. You are still enrolled in the Hoosier Healthwise program.

Your doctor's scope of practice may no longer meet your health care needs. This could be based on your age or other factors. Effective MM/DD/CCYY (day after pmp assignment end date), you may need a new doctor.

Please contact the Hoosier Healthwise Helpline at 1-800-889-9949.

Sincerely,

The Hoosier Healthwise Program

Figure I.11 – PCCM PMP Disenrollment-Re-enrollment in RBMC Letter to Member Not Auto-assigned; RBMC PMP Disenrollment-Re-enrollment in PCCM Letter to Member Not Auto-Assigned; RBMC PMP Disenrollment-Re-enrollment in Other RBMC Network Letter to Member Not Auto-Assigned

Date

Dr. PMP NAME
PMP Address
PMP Address
PMP Address (or blank if not needed)

Dear PMP Name,

Effective MM/DD/CCYY, you have been disenrolled from the following health plan network of the Hoosier Healthwise Managed Care program: Old Plan Name.

You have been enrolled as a Primary Medical Provider (PMP) with New Plan Name to provide services to Hoosier Healthwise members. Members assigned to you in the previous health plan network will be assigned to you in the new health plan network effective MM/DD/CCYY unless:

The member has chosen a different PMP

The member no longer meets the eligibility criteria for the Hoosier Healthwise Program

The member no longer matches your scope of practice criteria

If you have any questions regarding your enrollment, please call the Provider Services line at 1-XXX-XXX-XXXX for New Plan/Delivery System Name.

Sincerely,

The Hoosier Healthwise Program

Figure I.12 – PCCM PMP Disenrolling-Re-enrolling in RBMC in RBMC Letter to PMP, RBMC PMP Disenrolling-Re-enrolling in PCCM Letter to PMP; RBMC PMP Disenrolling-Re-enrolling in Another RBMC Network Letter to PMP

Date

Member's First and Last Name
Member Address Line 1
Member Address Line 2
Member City, State, Zip code

Dear Hoosier Healthwise Member:

Your Hoosier Healthwise doctor is changing service locations. You are still enrolled in the Hoosier Healthwise program.

Starting MM/DD/CCYY, your doctor or your doctor's address may have changed. This letter is to let you know that your doctor is:

Dr. PMP NAME
PMP Address
PMP Address
PMP Address (or blank if not needed)

PMP Phone: (XXX) XXX-XXXX

Health Plan: PrimeStep *(or)* MCO Name – MCO Network

Your doctor is in the Hoosier Healthwise health plan listed above.

Your doctor will treat you when you are ill. Your doctor will also arrange for other care, if you need it.

If you have any questions, please call Member Services for PMP's Network Name at 1-XXX-XXX-XXXX. Or you may also call the Hoosier Healthwise Helpline at 1-800-889-9949.

Sincerely,

The Hoosier Healthwise Program

Figure I.13 – PCCM/RBMC PMP Moving From an Individual Service Location to Group Service Location w/in Same Network PCCM/RBMC PMP Moving from a Group Service Location to an Individual Service Location Within the Same Network; PCCM/RBMC PMP Moving from an Individual Service Location to A Different Individual Service Location Within the Same Network; PCCM/RBMC PMP Moving From A Group Service Location to a Different Group Service Location Within the Same Network

Date

Member's First and Last Name
Member Address Line 1
Member Address Line 2
Member City, State, ZIP code

Dear Hoosier Healthwise Member:

Your Hoosier Healthwise doctor is changing service locations. You are still enrolled in the Hoosier Healthwise program.

Your doctor's scope of practice may no longer meet your health care needs. This could be based on your age or other factors. Starting MM/DD/CCYY (day after PMP assignment end date), you may need a new doctor.

Please contact the Hoosier Healthwise Helpline at 1-800-889-9949 as soon as possible in order to see if you need a new doctor.

Sincerely,

The Hoosier Healthwise Program

Figure I.14 – Change in Service Locations Letter

Appendix J: Hoosier Healthwise Inquiry, Grievance, and Appeal Proces

Table J.1 – Inquiry Process

Issue	Final Policy
1. Definition of an inquiry.	An inquiry is a concern or issue that is expressed orally by a member that will be resolved by the close of the next business day.
2. Timeframe for resolution of an inquiry.	The MCO must resolve an inquiry by the close of the next business day.
3. Notice of a resolution to the member.	Members are notified of a resolution of an inquiry by the close of the next business day. An inquiry resolved by the close of the next business day does not require a written notice of resolution to the member. Inquires resolved after the close of the next business day require a written notice of resolution to the member.
4. Reporting requirement.	Report monthly using the inquiry reporting form. Report separately for children with special health care needs and all other members.

Table J.2 – Grievance Process

Issue	Final Policy
1. Definition of a grievance and an expedited grievance.	A member or provider on behalf of a member may file a grievance orally or in writing. A grievance is any dissatisfaction expressed by the member or a provider on behalf of a member of a MCO regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between an enrollee and a MCO or group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. An inquiry that is not resolved by the close of the next business day becomes a grievance. An expedited grievance is defined as a grievance regarding an issue that would seriously jeopardize the life or health of a member or the member's ability to reach and maintain maximum function.
2. Timeframe for initial submission of a grievance or an expedited grievance.	A member will have 60 days from the day of the decision or event in question to file an oral or written grievance.
3. Timeframe for a MCO to acknowledge receipt of a grievance or an expedited grievance.	The MCO must acknowledge receipt of an oral or written grievance within three business days after the grievance is filed.
4. Timeframe for resolution of a grievance and an expedited grievance.	The MCO must resolve a written or oral grievance as expeditiously as possible, but not more than 20 business days after a grievance is filed. The grievance procedure must require an expedited grievance review if adhering to the 20 business day timeframe resolution would seriously jeopardize the life or health of a member or the member's ability to regain maximum function. Expedited grievance reviews must be resolved within 48-hours of the MCO's receipt of the review request.
5. Extension of the grievance resolution timeframe.	If the MCO is unable to make a decision regarding a grievance within the 20 business day period due to circumstances beyond its control, the MCO shall notify the member in writing of the reason for the delay within the 20 business day period. The MCO then must make a decision regarding the grievance within 10-business days after the date of the 20-business day timeframe expiration.
6. Notice of a resolution to the member.	The MCO must respond in writing to an enrollee within five business days after resolution of the grievance or expedited grievance. The resolution will include notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse appeal decision is made, if applicable. The MCO must make a reasonable effort to provide oral notification of expedited grievance resolutions. If the MCO denies the request for an expedited review, the MCO must transfer the grievance to the standard grievance timeframe, make a reasonable effort to provide the enrollee with prompt oral notification of the denial for an expedited review and follow-up with written notice within two calendar days.
7. Reporting requirement.	Report monthly using the grievance reporting form. Report separately for children with special health care needs and all other members.

Table J.3 – Appeal and Expedited Appeal Process

Issue	Final Policy
1. Definition of an appeal and an expedited appeal.	An appeal is a written request from a member or a provider on the behalf of the member to change a previous decision made by an MCO. An appeal includes any dissatisfaction expressed by the member or a provider on behalf of an enrollee of a MCO regarding the availability, delivery, appropriateness or quality of health care services and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. An expedited appeal review is defined as an issue that would seriously jeopardize the life or health of a member or the member's ability to regain maximum function.
2. Timeframe for submission of an appeal or an expedited appeal.	A member will have 30-calendar days from the day of the decision or event in question to file an appeal.
3. Timeframe for a MCO to acknowledge receipt of an appeal or an expedited appeal.	The MCO must acknowledge in writing the receipt of an appeal within three business days after the request for an appeal is filed.
4. Timeframe for resolution of a standard appeal or expedited appeal.	An appeal of a grievance decision must be resolved as expeditiously as possible with regard to the clinical urgency of the appeal. However, an appeal must be resolved within 30 business days. An expedited appeal review must be conducted within 48 hours of the MCO's receipt of the review request.
5. Extension of the appeal resolution timeframe.	If the MCO is unable to resolve the appeal within 30 business days because of circumstances beyond its control, the MCO must notify the member in writing on or before the end of the 30 business day timeframe that it requires more time to complete the process. The MCO must provide an explanation of the reason for the delay. The MCO then must make a decision regarding the appeal within 14 calendar days after the date of the 30-business day timeframe expiration.
6. Notice of a resolution to the member.	The MCO must notify the member of an appeal or expedited appeal resolution in writing within five business days after resolution of the appeal. The resolution will include notice of the member's right to file an External Independent Review request the process for requesting an External Independent Review, the expedited review options, the right to continue benefits during the review as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse review decision is made, if applicable. The MCO must make a reasonable effort to provide oral notification of expedited grievance resolutions. If the MCO denies the request for an expedited review, the MCO must transfer the appeal to the standard appeal timeframe, make a reasonable effort to provide the enrollee with prompt oral notification of the denial for an expedited appeal and follow-up with written notice within two calendar days.
7. Reporting requirement.	Report monthly using the appeal reporting form. Report separately for children with special health care needs and all other members.

Table J.4 – External Independent Review Process

Issue	Final Policy
1. Definition of a standard external independent review and an expedited external review.	The MCO shall establish and maintain an external grievance process for the resolution of grievances regarding an adverse utilization determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental. An expedited external review is defined as a review related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life, health, or ability to reach and maintain maximum function.
2. Timeframe for submission of a request for an external independent review.	A member or a provider on behalf member may file a written request with the MCO for an appeal of the MCO's grievance resolution not later than 45-calendar days after the enrollee is notified of the MCO's resolution.
3. Timeframe for the MCO to acknowledge receipt of a request for an external independent review.	The MCO must acknowledge receipt of a request for external independent review within three business days of receiving the request for an external independent review.
4. Timeframe for resolution of an external independent review and expedited external independent review.	A standard external independent review should be resolved within 15 business days after the standard review is requested. An expedited external independent review will be resolved within 72 hours of receipt of the request.
5. Notice of a resolution to the member.	For a standard review, the member is notified within 72 hours of the external independent review panel's decision. The resolution will include notice of the member's right to request a hearing to be conducted by the state Medicaid agency, the process for requesting a hearing by the state Medicaid agency, the right to continue benefits during the review as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse review decision is made, if applicable. [2] For an expedited review, the member is notified within 24 hours of the external independent review panel's decision. The resolution will include notice of the members right to and the process for requesting a hearing to be conducted by the state Medicaid agency, if applicable.
6. Reporting requirement.	MCO's shall report quarterly. Report separately for children with special health needs and all other members.

[2] For MCO members, all interim procedures must be exhausted prior to filing a request for FSSA hearing. Requests must be sent to the following address:
Indiana Family Social Services Administration
Hearings and Appeals Section, MS-04
402 W. Washington St., Room W392
Indianapolis, IN 46204-2773

Table J.5 – Medicaid Hearing and Appeal Process

Issue	Final Policy
1. Definition of a Medicaid hearing and appeal review.	A hearing for any person whose claim of assistance is denied or not acted upon promptly by the MCO. To include actions that the State Medicaid agency takes to suspend, terminate or reduce services.
2. Timeframe for submission of a request for a Medicaid hearing and appeal review.	A request for a Medicaid hearing and appeal review must be in writing and be submitted within 30-business days of the initial action that is being reviewed.
3. Medicaid hearing and appeal review process. The hearing and appeal process needs be pursued in the following order: • Administrative Law Judge Hearing • Agency review • Request for a law Judge Review	The member may request an Administrative Law Judge Hearing pursuant to *405 IAC 1.1-1-5.* Upon receipt of the Administrative Law Judge Hearing decision, the member may request an Agency review of the decision within 10 days of receipt of the administrative law judge decision. An Agency decision may be brought before a Judicial Review pursuant to *405 IAC 1.1-3-6.*
4. Timeframe for resolution of the Medicaid hearing and appeal review.	Member appeal hearings shall be conducted at a reasonable time, place and date. The Administrative Law Judge Hearing officer decision is due within 90 business days of the date that the request for a hearing is first made. Any party who is not satisfied with the decision of the Administrative Law Judge may request an Agency review of the decision within 10 business days of receipt of the Administrative Law Judge's decision. If a Medicaid applicant or member is not satisfied with the final action after agency review, he or she may file a petition for judicial review.
5. Extension of the Medicaid hearing and appeal review resolution timeframe.	A continuance of hearing will be granted only for good cause shown. Requests for continuance should be in writing and accompanied by adequate documentation of the reason(s) for the request.
6. Notice of resolution to consumer.	The parties will be issued a written notice of action taken as a result of agency review. If the decision of the Administrative Law Judge reversed, amended or modified, the secretary or designee shall state the reasons for action in writing.

Appendix K:Shadow Claims Processing Terminology

After Auditing Allowed Amount	The amount allowed for the claim based on the appropriate pricing methodology and the number of Medicaid allowed units. This is the fee-for-service allowance.
After Auditing Units	The number of units allowed after the claim has been audited against history (shadow and fee-for-service) and medical policy criteria. This is the number of Medicaid allowed units.
Before Auditing Allowed Amount	The amount allowed for the claim based on the appropriate pricing methodology and the number of billed units.
Before Auditing Units	The number of units allowed prior to auditing of the claim against history and medical policy criteria. This will equate to the billed number of units.
Capitation Indicator	A one-byte field added to the claims record, to identify services paid by the MCO on a capitated basis. This indicator is for informational purposes and has no impact on shadow claims processing.
CCF	Claim Correction Form. Used to obtain corrected or additional information from providers submitting fee-for-service claims. Because MCOs submit only fully adjudicated claims, this process does not apply to shadow claims.
Denied Shadow Claim Table	A record of all shadow claims that have been denied by the IndianaAIM system. These tables do not include claims that failed precycle editing. Information on a denied claim is not subject to service limitation auditing and is not included in data used for utilization review.
Manual Pricing	The process by which an allowed amount is determined for a procedure, which does not have a set rate on file. Shadow claims will not suspend for manual pricing. The "billed amount" will become the "allowed" amount.
MCO Identification Number	A nine-byte field used to identify the MCO submitting the shadow claim.
MCO Region Identifier	A one-byte field used to identify the region of the MCO submitting the shadow claim.
Paid Shadow Claim Table	A record of all shadow claims that have been processed and priced by the IndianaAIM system. With the exception of maternal delivery claims, paid shadow claims do not result in a financial transaction. Data from paid shadow claims is included in service limitation auditing and utilization analysis.
Post and Pay	The process by which an edit is attached to a claim for informational purposes only.
Shadow Claim Tables	The method by which the IndianaAIM system maintains shadow claims data. This data is stored on tables separate from fee-for-service claims but does not impact the user's ability to access either FFS or encounter data.
Shadow Claims	Reports of individual patient encounters with an MCO's delivery system that contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, service and billing providers. Shadow claims adjudicate in the same manner as fee-for-service claims, but do not result in a payment with the exception of claims submitted to report a maternal delivery.
Suspended Claims	Fee-for-service claims that have been held during processing to allow a manual review of data on the claim. Shadow claims will not suspend for any reason.
Third Party Liability (TPL)	Funds credited to Medicaid covered services for which the program would otherwise be liable. MCOs do not report TPL recoveries on their shadow claims. This data is reported in aggregate by the MCOs in a separate report.

Appendix L:Edit and Audit Disposition Change Request Form

Managed Care Organization Request for Edit and Audit Disposition Change for Shadow Claims

Please complete the following form in full and submit to Managed Care Director, EDS, 950 N. Meridian Street, 10th Floor, Indianapolis, IN 46204.

Name of organization submitting request: _____

Contact name at above organization regarding request: _____

Edit/Audit number: _____

Edit description: _____

Current disposition: _____

Reason for request: _____

_____

_____

_____

_____

Quantity of claims/month hitting edit: _____

Date submitted to EDS: _____

For EDS Use Only

Date received: _____

Date submitted to OMPP for approval: _____

Date request rejected: _____

Reason for rejection: _____

For OMPP Use Only

Date received: _____

Date approved: _____

Name/signature of OMPP staff approving request: _____

Figure L.1 – Edit and Audit Disposition Change Request Form

Appendix M: MCO Capitation Rate Cells

Table M.1 lists applicable MCO capitation rate cells.

Table M.1 – Managed Care Organization Capitation Rate Cells

Description	Capitation Categories
Package A Preschool Ages 1 to 5	A1
Package A Child Ages 6 to 12	A6
Package C Preschool Ages 1 to 5	C1
Package C Child Ages 6 to 12	C6
Package A/B Adult Females	AF
Package A Adult Males	AM
Package A Newborns 0-12 Months	NB
Package A/B Teens Ages 13 to 20	TN
Package A/B Delivery Payment	DP
Package A Children Ages 1 to 12 (prior to 1/1/01)	CH
Package C children Ages 1 to 12 (prior to 1/1/01)	CC
Package C Teens Ages 13 to 18	CT
Package C – Delivery Payment	CD
Package C – Newborns 0-12 Months	CN

Appendix N:Scheduled Capitation Payments

The capitation payment cycle always runs on the third Wednesday of every month and 820 files generate the following Saturday.

Table N.1 – 2005 Capitation Payment Dates

2005 Scheduled Dates for capitation cycle	
January 19	July 20
February 16	August 17
March 16	September 21
April 20	October 19
May 18	November 16
June 15	December 21

Appendix O: After Hours/24 Hours Availability Audit Quality Improvement

Quality Improvement Activity

Activity Name: *After Hours/24 Hours Availability Audit*

Purpose or Description

The purpose of the After Hours/24 Hour availability audit is to determine if there is appropriate and easy access to the primary medical provider (PMP) outside of regular business hours. The Hoosier Healthwise program ensures that members have the ability to obtain medical care 24 hours a day, seven days a week. PMP's are assessed on the process they have in place for the members to access a medical professional for urgent or emergent health care needs. The Office of Medicaid Policy and Planning (OMPP) recommends that Managed Care Organization include the following statement in PMP contracts and addendums:

"The PMP will be available 24 hours per day, seven days per week by telephone to the PMP, an employee, or designee of the PMP, an answering service, or pager system that immediately pages an on-call medical professional"

Audit or Reporting Schedule

This audit is performed quarterly. Findings are communicated in the Quarterly Report and in updates at the Quality Improvement Committee (QIC) meetings as indicated on the QIC schedule.

Selection Process

PMPs are randomly selected and the sample size is based on a 95 percent confidence rate with a plus or minus five percent margin of error.

Methodology

Each quarter a random sample of PMPs within each region is queried. Calls are made to the providers in the identified sample either before 8 a.m. or after 5 p.m. and on Saturdays, Sundays, and holidays. A call log is kept until the calls are completed. All calls are tabulated and the results posted with the noncompliance reasons stated and the corrective action identified.

Analysis

The goal is to have 100 percent compliance. Findings are summarized as indicated in the table below.

Table O.1 – Sample of Summarized 24-hour Availability Audit Results

Region	Number of Total PMPs called	Number of Satisfactory Results	Number of Unsatisfactory Results	Percent Compliance
North				
Central				
South				

Noncompliance rates consisted of responses included in the following sections:

Actions for Improvement

Providers noncompliant with the 24-hour availability requirement are notified and corrective action is required within 30 days of notification. Noncompliant providers are monitored in the following quarter to determine availability. These calls must be completed in addition to the quarterly monitoring sample.

Activities must be identified in the audit report as steps taken to communicate results to PMPs' offices and steps taken for any necessary actions to achieve future compliance.

Appendix P: OMPP Recommendations for Access Audit Process Update

Quality Improvement Activity

Activity Name: Primary Medical Providers Access Audit

Purpose or Description

The purpose of performing an access audit for the Hoosier Healthwise primary medical providers (PMPs) is to ensure that the participating PMPs provide timely and appropriate access to health services for established and new patients within a PMP's practice.

Audit Schedule

This audit is conducted annually by random sample.

Reported Time Period

An audit is performed during the fourth quarter of each year, reported in writing in the fourth quarter report, and reported verbally at the Quality Improvement Committee (QIC) meeting, as scheduled by the Office of Medicaid Policy and Planning (OMPP).

Sample Size

The sample size is determined based on the total population for each specialty by each Managed Care Entity (MCE). PMPs are randomly selected and the sample size is based on a 95 percent confidence rate with a plus or minus five percent margin of error.

Call Instructions

The auditor must perform the following actions when conducting a PMP access audit:

1. Place a telephone call to the PMP.
2. Document the date and name of the person taking the call.
3. Identify yourself as a representative for the Hoosier Healthwise program and state that you are conducting an access to care audit.
4. Request to speak with the person who does the appointment scheduling.
5. Ask the scripted questions relevant to the type of provider.
6. Document the actual date given for the appointment.

> *** If the next available appointment is with the nurse practitioner within a PMP office, that is acceptable.*

7. Document the results.

Quantifiers

The PMP in the random sample may need to be replaced with another PMP name in instances where:

1. The PMP is no longer in practice
2. The PMP was on medical leave

When a PMP needs to be replaced, all data representing the replacement is recorded. Choosing a replacement PMP is completed by identifying every third PMP on the non-sample list. This process provides consistency and maintains integrity of the randomized process. PMPs who are replaced are done so only due to issues unrelated to the access audit. Any problems encountered must be reported for follow-up activity.

- *Nurse practitioners*: A PMP office is considered to be in compliance with the appointment standards if available appointment dates fall within the recommended time frames. If there is a nurse practitioner in practice with the physician, appointment availability is based on the first available appointment with any medical provider in the office.
- *No response*: A PMP office that refuses to respond to the access audit is considered to be noncompliant with the appointment standards and must be recorded as No Response (NR).
- *Not Applicable*: There may be some circumstances in which a question does not apply. For example, an OB who does deliveries but does not provide GYN services. If the question does not apply to the PMP office then it must be recorded as not applicable (NA).

Appointment Standards

The appointment standards used are those accepted by the Hoosier Healthwise QIC. The 10 standards listed in Table U.1 are used to evaluate appropriate access to care.

Table P.1 – Hoosier Healthwise Quality Improvement Committee Accepted Appointment Standards

	Appointment Type	Appointment Time frame
1.	Urgent or emergent care	24 hours
2.	Non-urgent symptomatic	72 hours
3.	Routine physical exam	Three months
4.	Initial appointment (nonpregnant adult)	Three months
5.	Routine gynecological exam	Three months
6.	New obstetric patient	Within one month of date of attempting to schedule an appointment
7.	Initial appointment well child	Within one month of date of attempting to schedule an appointment
8.	Children with special health care needs	One month
9.	Average office wait time	Equal to or less than one hour
10.	Specialist referral: Emergency Urgent	 24 hours 48 hours

The standard for Children with Special Health Care needs must be addressed for patients who have a medical condition lasting (or will last) more than one year, require special equipment, or have physical access concerns.

Analysis

The analysis of the data is to be presented by specialty types of practice for each appointment type (see Table U.2 example) and an additional summary table for compliance with all appointment types (see Table U.3 example). Individual providers who participate in the study will be sent their individual results as well as the aggregate results of their peers. Any PMP who fails to meet the expected standards will be forwarded to the appropriate MCE Provider Services department for program education. All results are reported to OMPP in the table format below for **each** appointment access standard.

The percentages reported must represent the total for the type of practice for those who the standard is applicable. For example, if a total of 100 OB/GYNs were surveyed, but only 80 do routine gynecological exams, for the routine gynecological exam standard, the results would be divided by 80 to obtain the percentage of those who met the standard or did not meet the standard (including those who did or did not respond).

Table P.2 – Presentation of Data Analysis by Specialty Types of Practice

Appointment Type: [insert name of appointment type - provide one table for each type]								
Practice Type	**Met Standard**		**Did Not Meet Standard**				**Not Applicable**	
			Response Given		**No Response**			
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
OB/GYN								
Peds.								
FP/GP								

Table P.3 – Presentation of Data Analysis of Compliance by Appointment Types

Percent of Providers Who Did/Did Not Meet Standards For All Appointment Types								
Practice Type	**Met Standard**		**Did Not Meet Standard**				**Not Applicable**	
			Response Given		**No Response**			
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
OB/GYN								
Peds.								
FP/GP								

Actions for Improvement

1. A letter will be sent to all PMPs audited, thanking them for their continued support in the activities for the Hoosier Healthwise Program.
2. Information about any PMP who did not meet the standards is forwarded to the EDS Member and Provider Relations Department and a copy of the letter sent to the physician is placed in the PMP file.

Reporting Activity

The final results are provided to the Hoosier Healthwise QIC.

Appendix Q: EDS MCO Jobs Schedule

Schedule for Production Enrollment 834 Records and Reports

> *Note: Enrollment Roster jobs **always** run on the evenings of the 11th and 26th days of each month. Barring problems with the run, the change files and affiliated summary reports are always available for download from the EDS bulletin board (BBS) midday on the 12th and 27th days of each month. Audit files run after the 27th day of the month. Change files, audit files, and summaries are also available for download on the 27th.*

- January 12 – change
- January 27 – change and audit
- February 12 – change
- Februrary 27 – change and audit
- March 12 – change
- March 27 – change and audit
- April 12 – change
- April 27 – change and audit
- May 12 – change
- May 27 – change and audit
- June 12 – change
- June 27 – change and audit
- July 12 – change
- July 27 – change and audit
- August 12 – change
- August 27 – change and audit
- September 12 – change
- September 27 – change and audit
- October 12 – change
- October 27– change and audit
- November 12 – change
- November 27 – change and audit
- December 12 – change
- December 27 – change and audit

The dates listed above are approximate dates of processing and are subject to change.

Schedule for AFI Data Files

Note: AFI files are produced in conjunction with the 834 enrollment rosters.

- January 12
- January 27
- February 12
- Februrary 27
- March 12
- March 27
- April 12
- April 27
- May 12
- May 27
- June 12
- June 27
- July 12
- July 27
- August 12
- August 27
- September 12
- September 27
- October 12
- October 27
- November 12
- November 27
- December 12
- December 27

The dates listed above are approximate dates of processing and are subject to change.

Schedule for Production Capitation 820 Records and Reports

> *Note: The 820 is produced on the Saturday after the first Wednesday that falls on or after the 15th day of the month. Barring problems with the run, the 820 rosters and summary reports are available midday on the following day.*

- January 22
- February 19
- March 19
- April 23
- May 21
- June 18
- July 23
- August 20
- September 24
- October 22
- November 19
- December 24

The dates listed above are approximate dates of processing and are subject to change.

Schedule for MCO TPL Reports

> *Note: The jobs that create the MCO TPL files **always** run on the evening of the 20th day of each month. Barring problems with the run, the files are always available for download from the BBS during the early morning hours of the 21st day of each month.*

- January 21
- February 21
- March 21
- April 21
- May 21
- June 21
- July 21
- August 21
- September 21
- October 21
- November 21
- December 21

The dates listed above are approximate dates of processing and are subject to change.

Schedule for Provider Extract CD-ROM

> *Note: This job is not currently available for download from the BBS. A CD-ROM is created by the fifth business day of each month.*

- January 7
- February 7
- March 7
- April 7
- May 7
- June 7
- July 7
- August 7
- September 7
- October 7
- November 7
- December 7

The dates listed above are approximate dates of processing and are subject to change.

Schedule for Production MCO Ancillary Provider Files

> *Note: The jobs that process the MCO ancillary provider error files **always** run on the evening of the 20th day of every month. Barring problems with the run, the error files are always available for download from the BBS during the early morning hours of the 21st day of each month.*

- January 21
- February 21
- March 21
- April 21
- May 21
- June 21
- July 21
- August 21
- September 21
- October 21
- November 21
- December 21

The dates listed above are approximate dates of processing and are subject to change.

Glossary

Balanced Budget Act of 1997	*Federal Public Law 105-33* that makes numerous changes to various titles of the *Social Security Act* and creates a new Title XXI, the State Children's Health Insurance Program (CHIP).
CMS	Center for Medicare and Medicaid Services
Capitation	A prospective payment method that pays the provider of service a uniform amount for each person served, usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
Central Region	A Hoosier Healthwise enrollment area in Central Indiana that includes the following counties: Benton, Blackford, Boone, Carroll, Clinton, Delaware, Fayette, Fountain, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Jay, Johnson, Madison, Marion, Montgomery, Morgan, Parke, Putnam, Randolph, Rush, Shelby, Tippecanoe, Tipton, Union, Vermillion, Warren, and Wayne.
Children's Health Insurance Program (CHIP)	A part of the Balanced Budget Act of 1997 that includes an expansion of the Medicaid program that extends coverage to children ages zero to 19 years old whose family income is the FPL.
Clinical Advisory Committee (CAC)	The committee established by the OMPP comprised of actively participating medical providers enrolled in Hoosier Healthwise. The CAC's mission is to advise the OMPP concerning its policies by making recommendations that support the quality, accessibility, appropriateness, and cost-effectiveness of health and medical care provided to Hoosier Healthwise members.
DFR	Division of Family Resources
Drug Utilization Review (DUR)	Drug Utilization and Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/ HealthWatch Services	Those services described at *405 IAC 5-15* as required by Federal law pursuant to *42 U.S.C. 1396d*, which include certain preventive services to children under 21 years of age with emphasis given to early detection and prevention of conditions that can result in more costly treatment or long term effects.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
Emergency Services	With respect to an individual enrolled in a managed care organization, covered inpatient and outpatient services furnished by a provider who is qualified to furnish such services. Coverage also includes services that are needed to evaluate or stabilize an emergency medical condition.
EQRO	External Quality Review Organization

Family and Social Service Administration (FSSA)	FSSA. The OMPP is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
Federally Qualified Health Center (FQHC)	A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
HCFA	Health Care Financing Administration (Currently known as CMS).
Health Insurance	Includes, but is not limited to, coverage by any health care insurer, Health Maintenance Organization, or an employer-administered ERISA plan.
Home and Community Based Services (HCBS) Waiver Program	A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
Hoosier Healthwise	The managed care component of the Indiana Health Coverage Programs for the TANF, Pregnancy Medicaid and Children's Medicaid populations in which medical care is available in risk-based managed care (MCO) networks.
Hoosier Healthwise for Persons with Disabilities (HHPD)	A voluntary risk-based managed care program for the IHCP enrollees who are considered disabled or chronically ill according to the state's established criteria. This pilot program, available in Marion County from January 1997, through December 1999 has been discontinued, but may be reinstated at a later time.
IndianaAIM	The Indiana Advanced Information System; another name for the State's Medicaid Management Information System (MMIS).
Indiana Family and Social Services Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under IFSSA, is the single State agency responsible for the administration of the IHCP. Also referred to as FSSA.
MCE	Managed Care Entity
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and primary health providers (PHPs).
Managed Care Organization Enrollee or Member	An IHCP or CHIP enrollee participating in Hoosier Healthwise and enrolled in one of the Hoosier Healthwise managed care organizations.
Managed Care for Persons with Disabilities (MCPD)	See Hoosier Healthwise for Persons with Disabilities
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

Medicaid-covered service	A service provided or authorized by an IHCP provider for an IHCP enrollee for which payment is available under the IHCP as set forth in *405 IAC 5*. A list of covered services is referenced in *IC 12-15-5-1*.
Medicaid Management Information System (MMIS)	The IHCP payment and information system of the Indiana Family and Social Services Administration; also known as Indiana*AIM*.
Medicaid Recipient/Indiana Health Coverage Programs Member	An IHCP enrollee in one of these aid categories: Aged; Blind and Disabled; Temporary Assistance for Needy Families; Pregnancy Medicaid; Children's Medicaid.
Medically Necessary	Medically necessary services covered by the IHCP are specified in *405 IAC 5*.
Member or Enrollee	A A person who receives an IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Program.
Northern Region	A Hoosier Healthwise enrollment area in Northern Indiana that includes the following counties: Adams, Allen, Cass, Dekalb, Elkhart, Fulton, Huntington, Jasper, Koscioko, LaGrange, LaPorte, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Wabash, Wells, White and Whitley.
Office of Medicaid Policy and Planning (OMPP)	The office within the Indiana Families and Social Services Administration that is the designated state agency administering the Indiana Health Coverage Programs. The OMPP is responsible for developing the policies and procedures for Hoosier Healthwise.
Quality Assurance/ Quality Control (QA/QC)	QA/QC are interrelated methods of monitoring the services that MCOs arrange or administer for its enrollees.
Quality Improvement Committee (QIC)	The committee established by the OMPP that provides oversight for the appropriateness and quality of care provided to enrollees by establishing standards and guidelines for the provision of care. The QIC is responsible for integrating the quality improvement process and services as a coordinating and advisory body.
RHC	Rural Health Clinic. A cost-based reimbursement system of clinics created under the *Rural Health Clinic Services Act of 1977* to provide better access to services for people in rural, medically underserved areas through the use of mid-level practitioners.
Shadow Claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, shadow claims from MCOs contain FFS-equivalent detail regarding procedure, diagnosis, place of service, billed amount, and the rendering or billing provider information.
Southern Region	A Hoosier Healthwise enrollment area in Southern Indiana that includes the following counties: Bartholomew; Brown, Clark, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Floyd, Franklin, Gibson, Greened, Harrison, Jackson, Jefferson, Jennings, Knox, Lawrence, Martin, Monroe, Ohio, Orange, Owen, Perry, Pike, Posey, Ripley, Scott, Spencer, Sullivan, Switzerland, Vanderburgh, Vigo, Warrick, and Washington.

SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: Statistical analysis Exception processing Provider and member profiles Retrospective detection of claims processing edit and audit failures and errors Retrospective detection of payments and utilization inconsistent with State or federal program policies and medical necessity standards Retrospective detection of fraud and abuse by providers or members Sophisticated data and claim analysis including sampling and reporting General access and processing features General reports and output
TANF	Temporary Assistance for Needy Families. Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Third Party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
Utilization Review (UR)	A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.

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